

Zimbabwe Health Interventions

Accelerated and Comprehensive HIV Care for Epidemic Control in Zimbabwe (ACCE) Project



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Abbreviations

AHD	Advanced HIV Disease
ANC	Antenatal Care
ART	Antiretroviral Therapy
AGYW	Adult Girls and Young Women
BRTI	Biomedical Research and Training Institute
CARG	Community ART Refill Group
CLA	Collaboration Learning and Adapting
CoT	Continuity of Treatment
CrAg	Cryptococcal Antigen
CRF	Clinical Referral Facilitator
CRS	Catholic Relief Service
DATIM	Data for Accountability, Transparency and Impact
DHE	District Health Executive
DHIS2	District Health Information System version 2
DREAMS-RISE	Determined Resilient Empowered AIDS-Free Mentored Safe – Re-Ignite Innovate Sustain Empower
DNA	Deoxyribonucleic Acid
DPS	Department of Pharmaceutical Services
DSD	Differentiated Service Delivery
DSD	Direct Service Delivery
DTG	Dolutegravir
DQA	Data Quality Assessments
EID	Early Infant Diagnosis
EMMP	Environmental Monitoring and Mitigation Plan
eMTCT	Elimination of Mother-to-Child Transmission (of HIV)
FHI 360	Family Health International 360
FtS	Flip the Script
FY	Fiscal Year
GHSC-PSM	The USAID Global Health Supply Chain Program-Procurement and Supply Management
GBV	Gender Based Violence
GOZ	Government of Zimbabwe
HCW	Health Care Worker
HEI	HIV exposed infants
HIV-ST	HIV Self Testing
HRH	Human Resources for Health
HFR	High Frequency Reporting
HPV	Human Papilloma Virus
HTS	HIV Testing Services
ICT	Index Case Testing
IEC	Information, Education and Communication
INH	Isoniazid

IPV	Intimate Partner Violence
KPI	Key Performance Indicator
KYA	Know Your Award
LAM	Lipoaribomannan
LEEP	Loop Electrosurgical Excision Procedure
MBP	Mother Baby Pair
MMD	Multi-month Dispensing
MOHCC	Ministry of Health and Child Care
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NMRL	National Microbiology Reference Laboratory
NNRTI	Non-nucleoside reverse transcriptase inhibitors
OI/ART	Opportunistic Infections/Antiretroviral Therapy
OIG	Office of Inspectorate General
OVC	Orphans and Vulnerable Children
OW	Outreach Worker
PDSA	Plan Do Study Act
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal Care
PrEP	Pre-exposure Prophylaxis
PLHIV	People Living with HIV
POC	Point of Care
QA	Quality Assurance
QI	Quality Improvement
RDQA	Routine Data Quality Assessment
SAC	Special Award Conditions
STI	Sexually Transmitted Infection
TA	Technical Assistance
TAT	Turnaround Time
TB	Tuberculosis
TLD	Tenofovir Lamivudine and Dolutegravir
TOP	Tip of Anonymous
TPT	TB Preventive Therapy
TQLA	Total Quality Leadership and Accountability
USAID	United States Agency for International Development
VIAC	Visual Inspection with Acetic Acid
VL	Viral Load
VLS	Viral Load Suppression
WRA-LHIV	Women of Reproductive Age Living with HIV
ZHI	Zimbabwe Health Interventions

I.0 Executive Summary

The United States Agency for International Development (USAID) awarded Zimbabwe Health Interventions (ZHI) a 5-year U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funded HIV prevention, care, and treatment in September 2021. The project is being implemented in nine districts in Manicaland and Midlands provinces and is known as the Accelerated Comprehensive HIV Care for Epidemic Control (ACCE) project. The project's main goal is to complement the government of Zimbabwe's (GoZ) efforts towards the attainment and sustainability of HIV epidemic control in Zimbabwe. The ACCE project is implemented in close collaboration with the Ministry of Health and Child Care (MOHCC), as well as Africaid (now Zvandiri) and FHI 360 as sub-recipients. Other stakeholders include the National AIDS Council (NAC), FACT, Catholic Relief Services (CRS), Biomedical Research and Training Institute (BRTI) and Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM).

This is a performance progress report to mark the end of the first year of implementation (October 01, 2021 – September 30, 2022) of the ACCE project. The report focuses on the project's cumulative programmatic performance, challenges, and lessons learned during implementation. The following is a summary of the major ACCE project's achievements:

In the period under review, the ACCE project implemented activities within the technical framework of the ACCE mechanism description outlined in the approved Cooperative Agreement in the nine supported districts. Table I summarizes the ACCE project achievements on key performance indicators (KPI), benchmark for the annual period is 100% of annual targets. As shown in the table, the project managed to achieve most of the key performance indicators which is indicated by the indicators in green. However, there are still areas that need to be addressed for improvement and these have been prioritized in the Country Operational Plan (COP) 2022.

Table 1: Summary of Key Performance Indicators

Key Performance Indicator	Annual Target	Cumulative Achievement	% Annual Performance
HTS_TST	178,968	244,937	● 137%
HTS_TST_POS	12,702	12,668	● 100%
HTS_SELF	30,456	82,770	● 272%
HTS_INDEX	27,588	19,994	● 72%
TX_NEW	12,208	12,278	● 101%
TX_CURR (DSD)	220,289	220,541	● 100%
TX_CURR (TA&DSD)	288,074	282,667	● 98%
TX_NET_NEW (DSD)	6,132	6,137	● 100%
TX_NET_NEW (TA&DSD)	8,832	8,671	● 98%
TX_PVLS (DSD)	217,875	152,007	● 70%
TX_PVLS (TA&DSD)	282,827	169,728	● 60%
CXCA_SCRN (aged 25-49)	44,324	50,356	● 114%
PMTCT_STAT	60,564	84,570	● 140%
PMTCT_ART*	5,997	7,410	● 124%
PMTCT_EID*	5,997	11,576	● 193%
TB_STAT*	9,120	2,927	● 32%
TB_ART*	5,068	1,584	● 31%
PREP_NEW	4,504	9,829	● 218%

Key



Greater or equal to 90%



60% to 89%



Less than 60%

2.0 Introduction

In September 2021, USAID awarded ZHI a five-year (October 01, 2021, to September 30, 2026) PEPFAR funded Cooperative Agreement of approximately US\$70 million to complement the Government of Zimbabwe (GOZ)'s efforts to attain and sustain HIV epidemic control in Zimbabwe. ZHI and its consortium partners, namely FHI 360 and Africaid (now Zvandiri), are implementing the USAID PEPFAR funded ACCE project in two provinces (Manicaland and Midlands) in Zimbabwe. The overall goal of the project is to contribute to the attainment and sustainability of HIV epidemic control in Zimbabwe through the following five strategic objectives.

- **Objective 1:** To provide site-level technical assistance (TA) that ensures comprehensive implementation of national guidelines, procedures, and other standards of practice at service delivery points to maintain and/or improve quality of services provided at health facilities for the prevention of new HIV infections.
- **Objective 2:** To increase access and availability of quality, effective, targeted, and efficient HIV testing services to find remaining undiagnosed cases of People Living with HIV (PLHIV) and/or known positives not on ART in implementing districts through site level TA and direct community service delivery.
- **Objective 3:** To maintain and/or improve quality of services provided at health facilities for linkage to ART and retention in care of PLHIV to achieve durable viral load suppression.
- **Objective 4:** To advance and strengthen strategic information and evaluation for data-driven and evidence- based implementation.
- **Objective 5:** To provide TA to the national level of the health care system 1) for development/review/assessment of policies, strategies, guidelines etc., that will enable a coordinated national HIV response and 2) to ensure program monitoring with district/provincial data utilization and deployment of appropriate national-level responses/support.

The ACCE technical approach is anchored on quality, client-centered, and integrated programming across the continuum of HIV care, ensuring data-driven decision making at all program levels. Below is the ACCE Conceptual Framework (Figure 1):

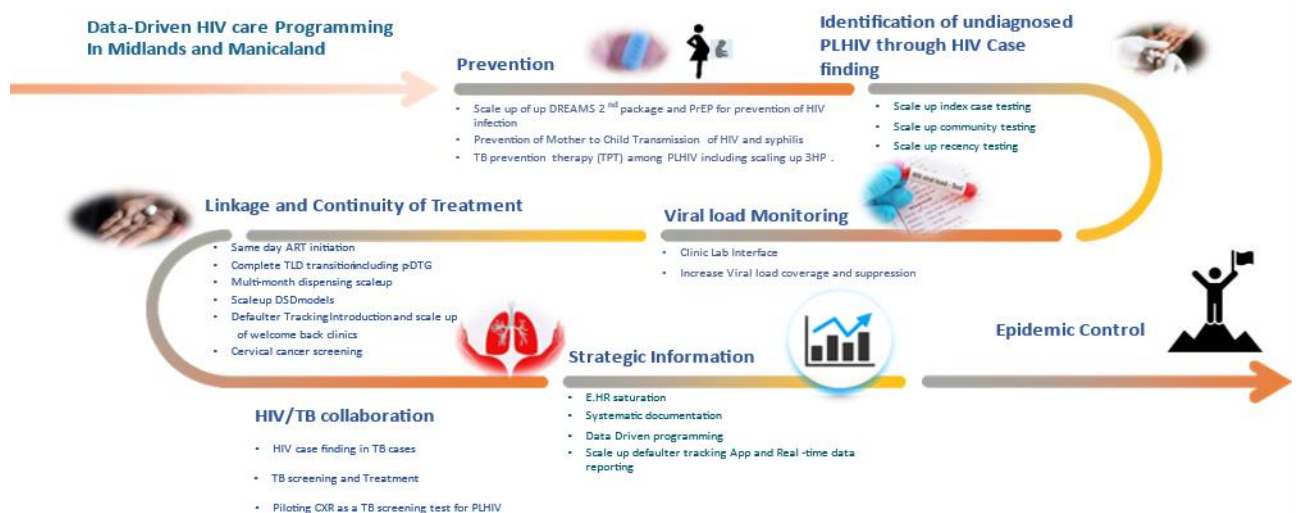


Figure 1: ACCE Conceptual Framework

The project has a focus on scaling up game-changing, evidence-based interventions and innovations such as pre-exposure prophylaxis (PrEP), Tuberculosis (TB) preventive therapy (TPT), HIV self-testing

(HIV-ST), cervical cancer screening among other key HIV prevention, care, and treatment interventions. Through collaboration with Africaid (now Zvandiri), FHI360 and the Determined Resilient Empowered AIDS-Free Mentored Safe (DREAMS) project in selected facilities, the project supported provision of comprehensive HIV prevention, care, treatment, and support services for children, adolescents, and young persons living with HIV (CAYPLHIV).

Through TA, dynamic capacity-building modalities (site-based coaching, mentoring), subnational secondments, and direct service delivery, ACCE worked closely with the Ministry of Health and Child Care (MOHCC) to expand and improve access to quality and comprehensive HIV prevention, care and treatment. The program also focused on effective prevention of and responses to gender-based violence (GBV), HIV prevention among populations at substantial risk of HIV, greater reach of TB and cervical cancer screening and treatment services, rapid ART initiation using optimized regimens, and treatment continuity for viral suppression.

2.1 ACCE COP21 Geographic Scope

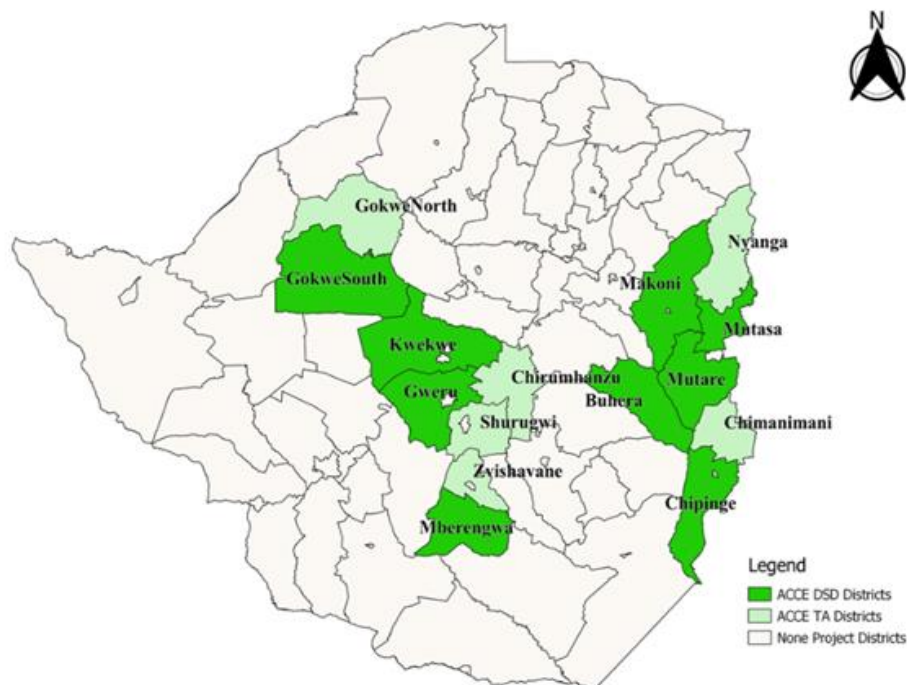


Figure 2: ACCE Geographic Scope

The program is implemented in nine direct service delivery (DSD) districts across two provinces of Zimbabwe, namely Gokwe South, Gweru, Kwekwe and Mberengwa in Midlands province and Buhera, Chipinge, Makoni, Mutare, and Mutasa in Manicaland province (Figure 2). Gweru, Kwekwe and Mutare districts have both rural and urban settings, while the remaining 6 DSD districts are classified as rural. The project also supported the other six districts in the two provinces which are referred to as the technical assistance for treatment (TAT) districts and these are Chimanimani and Nyanga in Manicaland and Shurugwi, Gokwe North, Zvishavane and Chirumhanzu in Midlands.

Manicaland province shares a border with Mozambique and is typified by a mountainous terrain. There is extensive farming activity in tea plantation estates in Mutasa district and a tertiary education institution in Mutare (Africa University). Mutare & Buhera districts have a high population of the apostolic sect. Midlands province is characterized by widespread mining including artisanal mining, and houses one of the largest universities in the country (Midlands State University) in Gweru City. There is also heavy indigenous religious (apostolic) sect presence in Gokwe South district and Manicaland province.

The Apostolic sect openly objects the uptake of modern healthcare services including HIV prevention, care, and treatment. Religious teaching and church regulations of Apostolic Faith groups fundamentally shape health care seeking behaviour of the communities in these districts. The mining sector is largely a male dominated field and according to MOHCC data, men are of low health seeking behaviour hence they are less likely to be tested for HIV and they tend to present with advanced HIV disease (AHD).

2.2 ACCE Results Framework

The ACCE project is expected to contribute to the following outcomes in the implementation provinces and districts:

Long term outcomes:

- Reduce MTCT rate from 7.8% to less than 5% by September 2026.
- Reduce HIV incidence within supported provinces by 20% by September 2026.

Short to intermediate outcomes:

- 100% of clients receive GBV/IPV screening and linkage to post violence services.
- 95% of PLHIV in all ages and sex know their HIV status.
- At least 95% of PLHIV in all sub-population groups initiated on ART.
- At least 95% ART clients retained on ART.
- 100% of WRA-LHIV offered cervical cancer screening.
- 100% of sites offer Differentiated Service Delivery (DSD) and 6 Multi-month Dispensing (MMD).
- At least 95% of ART clients reach viral load suppression (VLS).
- 100% of PLHIV are screened for TB.
- 100% of ART clients receive mental health screening and referrals.
- 100% of sites have functioning EHR.

3.0 Detailed ACCE annual performance by technical area/strategic objectives

3.1 To contribute to the reduction of new HIV infections in Zimbabwe through provision of comprehensive prevention services within the national HIV program.

3.1.1. Prevention of Mother-to-Child Transmission (PMTCT) of HIV

Cumulatively, 86,233 pregnant women booked for first antenatal care (ANC) against an expected pregnancy of 100,977 (85%). Among those, 98% knew their status at entry into ANC services. The HIV testing yield in ANC was 2% and all were linked to ART. All those who booked with a known HIV positive status were already on ART as shown in figure 3 below:

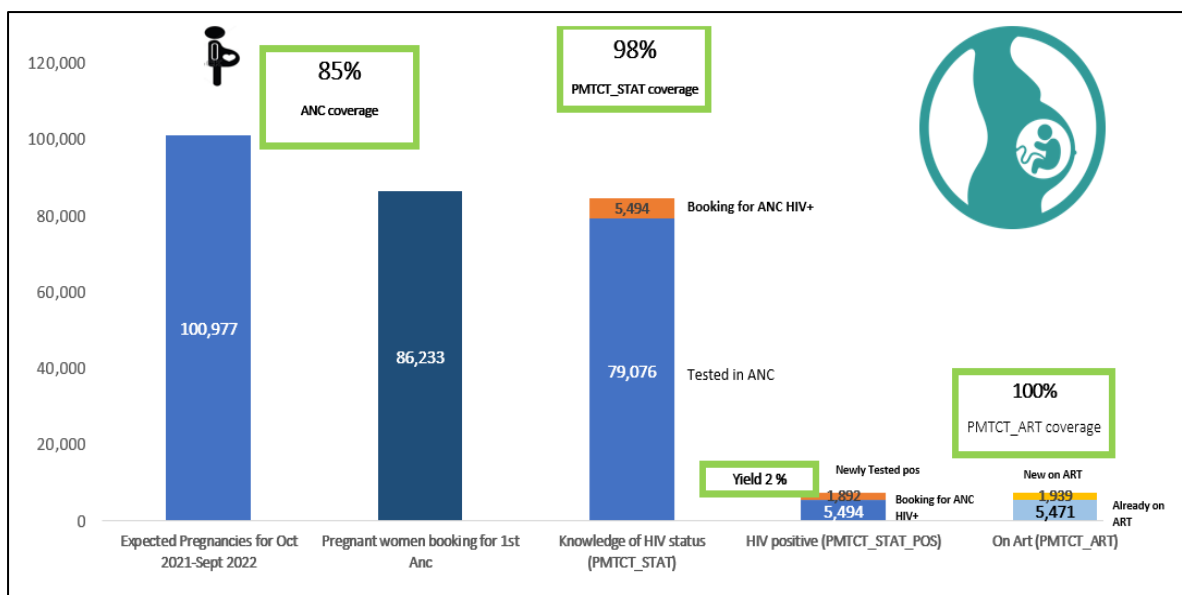


Figure 3: Overall ACCE PMTCT Cascade October 2021- September 2022

Despite the great achievement within the PMTCT cascade (PMTCT_STAT, PMTCT_ART), the upstream indicator, ANC coverage, remains low at 85% against the 95% target in both provinces with Manicaland province having the least coverage (83%) compared to 88% in Midlands. Only three out of the nine districts have coverages above 95% and the low ANC coverage is a barrier towards achieving elimination of mother to child transmission (eMTCT) of HIV and congenital syphilis. To address this low ANC coverage the ACCE project has strengthened engagements with community partners (Jointed Hands Welfare Organization in Midlands) and partners working in Maternal, Child and Neonatal Health (Mhuri/Imuli in Manicaland) through the community nursing department to work towards improvements in ANC coverage. User fees at local city clinics are among the key barriers especially in districts like Makoni, Kwekwe, and Gweru while religious objectors affected mainly Buhera, Makoni and Mutare districts. The ACCE project advocated for abolishment of user fees and in Manicaland province, a meeting has been held with the Mutare City Council and we are expecting a positive response. The multi-sectoral platforms led by NAC have also been used for advocacy including meaningful engagement with religious leaders in Gokwe South, Mutare, Makoni and Buhera. During the period under review and in particular the last half of the implementation year, the ANC coverages also went down across the country, and this also coincided with the period when Coronavirus Disease 2019 (COVID19) and Measles/Rubella vaccination campaigns which left most facilities manned by less experienced personnel e.g., nurse aides who are not well capacitated in providing ANC services.

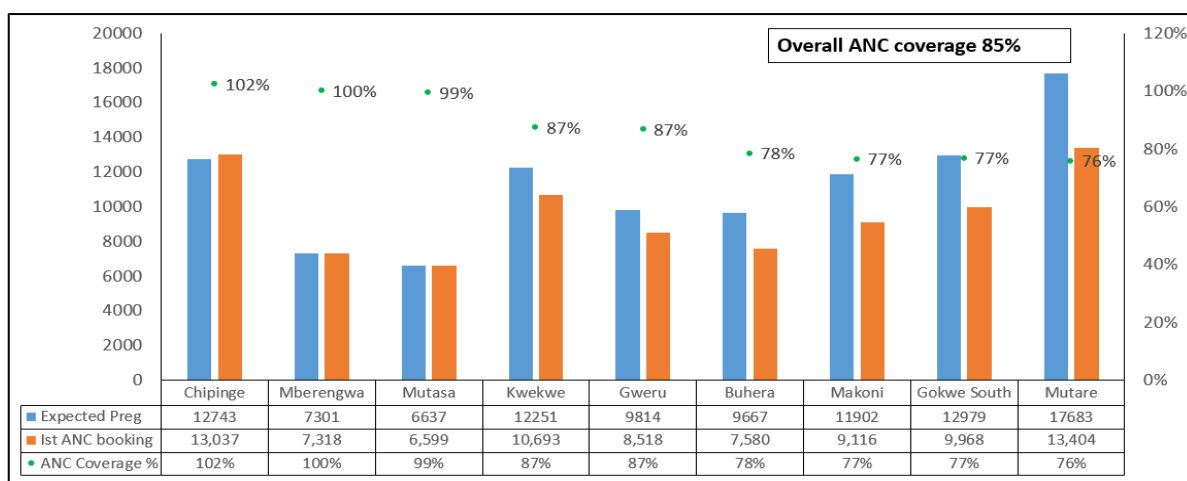


Figure 4: ANC Coverages by district October 2021- September 2022

3.1.2 Syphilis testing and treatment

Syphilis testing coverages have remained above 95% in all the nine districts. Kwekwe and Mutasa had coverages above 100% as they conducted backlog clearing among missed clients from previous reporting period. The missed clients in Mberengwa, Gokwe, Gweru and Chipinge were treated after the reported period and will appear in Q1 COP22 report. District treatment rates are shown in figure 5 below:

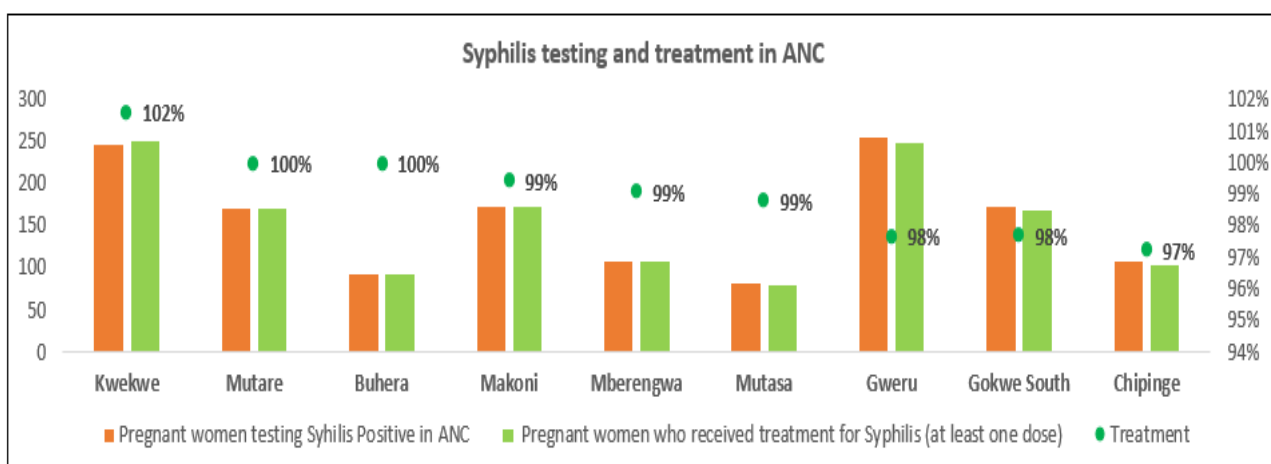


Figure 5: ACCE District Syphilis Testing & Treatment Cascade October 2021 – September 2022

3.1.3 Early Infant Diagnosis

Table 2 shows the overall performance of the PMTCT and early infant diagnosis (EID) for the implementation year. During the period under review, a total of 11,576 samples for EID were collected and tested for HIV among the HIV exposed infants (HEI). Of these 2,578 (22%) were tested at birth (within 72hrs of birth), 5,741 (50%) were tests for HEI aged 3 days – 2 months, 2,803 (24%) were tests for children aged 3-12 months and only 454 (4%) were tests for children between 12 – 24 months. The positivity rates show an increase from 1% for those tested at birth to -2 months to 2.6% for those tested at 3-12 months and 11.7% for those tested at 13 – 24 months (table 2).

Table 2: Overall ACCE PMTCT_EID Performance October 2021 - September 2022

HIV Exposed Infants with EID sample collected (POC /DBS) and Results													Total Sample collected and Results		
Infants Ages	<=72 hours			73 hours - 2 months			3 - 12 months			13 - 24 months			Sample collected	Tested HIV+	Initiated on ART
	Sample collected	Tested HIV+	Initiated on ART	Sample collected	Tested HIV+	Initiated on ART	Sample collected	Tested HIV+	Initiated on ART	Sample collected	Tested HIV+	Initiated on ART			
Buhera	285	0	0	343	4	4	268	4	5	32	2	3	928	10	12
Chipinge	214	7	8	524	6	5	270	8	8	53	6	7	1,061	27	28
Makoni	253	1	0	738	5	5	419	7	7	76	3	3	1,486	16	15
Mutare	200	1	0	796	8	9	464	13	13	67	11	13	1,527	33	35
Mutasa	337	4	4	405	5	5	149	2	2	60	4	4	951	15	15
Gokwe S	138	2	2	566	3	5	291	11	10	37	6	8	1,032	22	25
Gweru	555	5	5	934	7	3	352	7	10	49	8	7	1,890	27	25
Kwekwe	434	5	4	825	5	5	413	18	16	56	10	10	1,728	38	35
Mberengwa	162	1	0	610	9	6	177	3	5	24	3	5	973	16	16
Total	2,578	26	23	5,741	52	47	2,803	73	76	454	53	60	11,576	204	206

Further analysis of the early infant diagnosis performance shows gap in the follow-up of HIV exposed infants with less children accessing testing as they age (see table 3). The high positivity rate indicates that as the children age, the testing is more targeted to those who probably present ill. To address this gap, the project will continue to promote the use of point of care (POC) EID testing and ensure adherence to the EID testing algorithm in line with MOHCC guidelines and reporting of the final outcomes. This will be achieved through strengthening commodity security and specimen and result transportation (figure 6). The project will also enhance longitudinal tracking up to the end of mother to child transmission (MTCT) risk period through strengthening use of the Mother Baby pair (MBP) registers. To achieve this, the project will leverage on collaborations with the OVC partners who are closer to the community and also have the paediatric case finding as a key strategic objective. We will also utilise the community-based cadres (outreach workers, clinical referral facilitators and village health workers) who will assist with tracking of these infants to ensure testing according to the national guidelines and prompt ART initiation of those testing HIV positive.

Table 3: Access to HIV testing by HIV Exposed Infants analysis by age October 2021 – September 2022

Age of HIE infants at test	Number tested	Number Positive	Positivity Rate
0-72hrs (birth testing)	2, 578	26	1,0 %
73hrs – 2 months	5, 741	52	0.9%
3 – 12 months	2, 803	73	2.6%
13 – 24 months	454	53	11.7%
Total	11, 576	204	1.8%

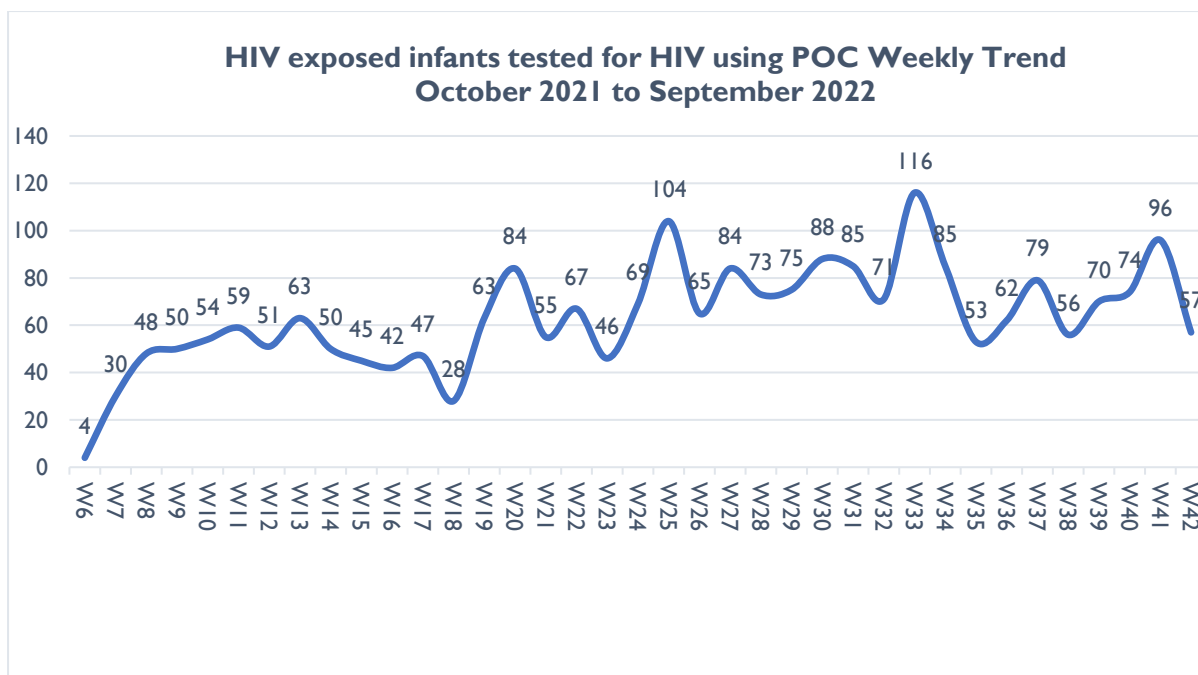


Figure 6 : EID using POC platforms October 2021 to September 2022 in Manicaland and Midlands ACCE sites.

Among the HIV exposed infants confirmed to be HIV positive through EID, the project achieved 101% linkage to ART. This was due to some children identified the previous reporting period but initiated on ART in this current reporting period. However, some children whose initiations were pending at the time of compiling this report and are still being followed up for ART initiation in Q1 COP22. The ACCE project supported the MOHCC monitoring and evaluation team with collection and entry of infant case notification data and cumulatively, 86% of the infant cases were captured in District Health Information System version 2 (DHIS2) by September 2022. At the time of compilation of this report, the project teams were following up on all initiations to ensure entry into DHIS2.

3.1.4 Provision of Pre-Exposure Prophylaxis (PrEP) services

The project surpassed the annual target of 4, 504 having reached 9,829 (218%) for PrEP initiations by end of September 2022. Further analysis of PrEP provision indicates that 22% of the recipients were adolescent girls and young women (AGYW) (15 – 24 years) and less than 3% was provided to pregnant and lactating women. Moving into COP22, deliberate efforts have been made to ensure that we increase PrEP provision for the priority populations including pregnant and lactating women. These include ensuring PrEP commodity security and availability at all key entry points in healthcare facilities, and capacity building of healthcare workers in the key entry points (e.g., the Healthcare workers in ANC, post-natal care (PNC), and outpatients department). The ACCE project will also strengthen collaboration with the DREAMS partners in the districts where DREAMS is being implemented. All districts surpassed their annual targets (Table 4).

Table 4: ACCE PREP_NEW Performance October 2021- September 2022

District	PREP_NEW		
	Annual Target	Started on PrEP	% Achievement
Buhera	192	541	● 282%
Chipinge	700	922	● 132%
Makoni	827	1079	● 130%
Mutare	933	1618	● 173%
Mutasa	119	643	● 540%
Gokwe South	198	1141	● 576%
Gweru	1065	1929	● 181%
Kwekwe	291	1426	● 490%
Mberengwa	179	530	● 296%
Totals	4504	9829	● 218%

3.1.5 DREAMS Program

Whilst the ACCE project surpassed PrEP targets during the period under review, provision of PrEP and other services sexually transmitted infection (STI) screening, Family Planning, (GBV) for targeted populations, particularly the AGYW under the DREAMS program was suboptimal. This was partly due to delayed implementation and capacity building of ACCE project staff as well as MOHCC healthcare workers on the DREAMS program.

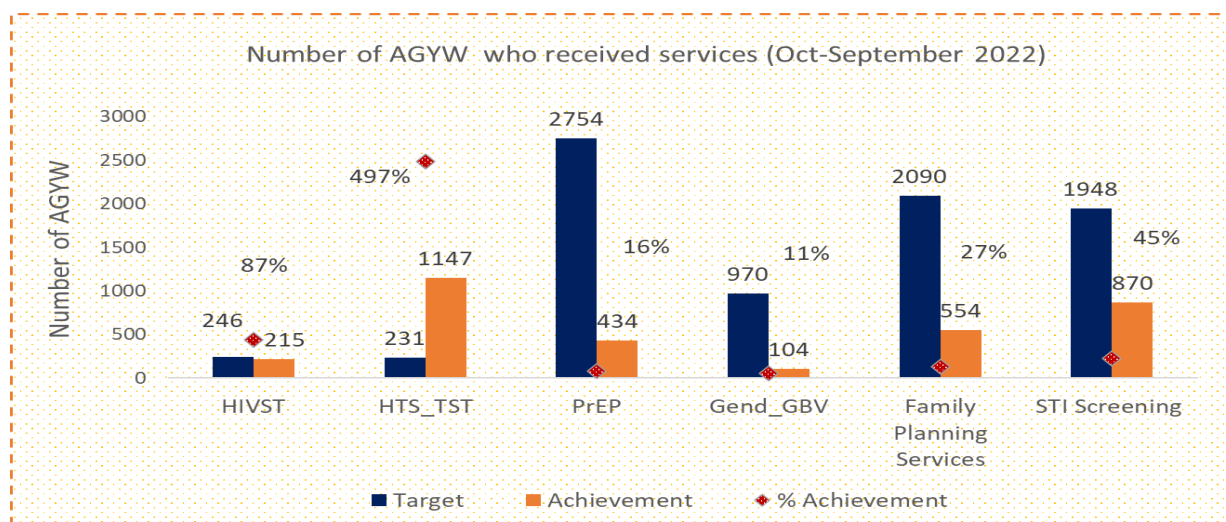


Figure 7: ACCE DREAMS-RISE program performance

The ACCE project implemented some interventions in Quarter 4 to improve the performance under the DREAMS program which included collaboration with the community DREAMS partners (DREAMS-RISE in Gweru and FACT in Manicaland). Capacity building of both MOHCC and ACCE project staff in DREAMS program implementation was conducted with an emphasis on documentation and referral completion. This capacity building was conducted mostly for tier one sites and in COP 22 this will be expanded to tier two and three sites. However, user fees especially in the urban sites in Mutare and Gweru continue to be a barrier to access to DREAMS secondary package which includes provision of contraceptives and treatment of STIs for eligible clients.

The following strategies will be employed in COP22 to address the DREAMS program performance.

1. The capacity building sessions will continue into COP22 so that we have a trained cadre at each healthcare facility.
2. Focal persons at district level have been identified to work closely with the DREAMS partners to ensure collaboration and complete referrals for the AGYW. We have started implementing the following in COP21 and this will continue into COP22.
 - a. Active tracking of referrals through close collaboration with the DREAMS Community partners.
 - b. Participation in the weekly referral meeting in the four districts. During the meeting, our SIE teams work together with the other DREAMS partner to de-duplicate the numbers before reporting.
3. To rectify the documentation challenge.
 - a. Data collecting tools (FI form) have been disseminated to all the facilities in the DREAMS districts.
 - b. Complete referral forms for previously missed clients who had form I completed without referral form and submit to Out of School Club Facilitators and update database. Before capturing the forms at district level, confirmations with the FACT and RISE will be done to avoid referring adolescents who previously received service from DREAMS.

3.1.5.1 Intimate Partner Violence (IPV) screening and post gender-based violence (GBV) care

A total of 2, 976 post GBV clients were seen in the period under review and 896 (30%) were ART experienced. On intimate partner violence (IPV) screening, the ACCE project screened 7, 667 clients, mainly through index case testing. Of those that were screened, 360 (4.6%) were experiencing intimate partner violence and 109 (30%) were referred for IPV services (Figure 8). Clinical services including STI screening, testing and treatment, rapid HIV testing and treatment for injuries were available across all facilities. Additionally, sites had processes to facilitate referrals for clients to other GBV response services and confidentiality was assured when asking about GBV /IPV.

In COP22, the ACCE project will continue to strengthen the GBV and IPV program through on-job mentorship on routine IPV enquiry in PLHIV and expansion of LIVES training support to Clinical Referral Facilitator (CRF), Outreach Worker (OWs) and other facility staff as part of the comprehensive GBV response.

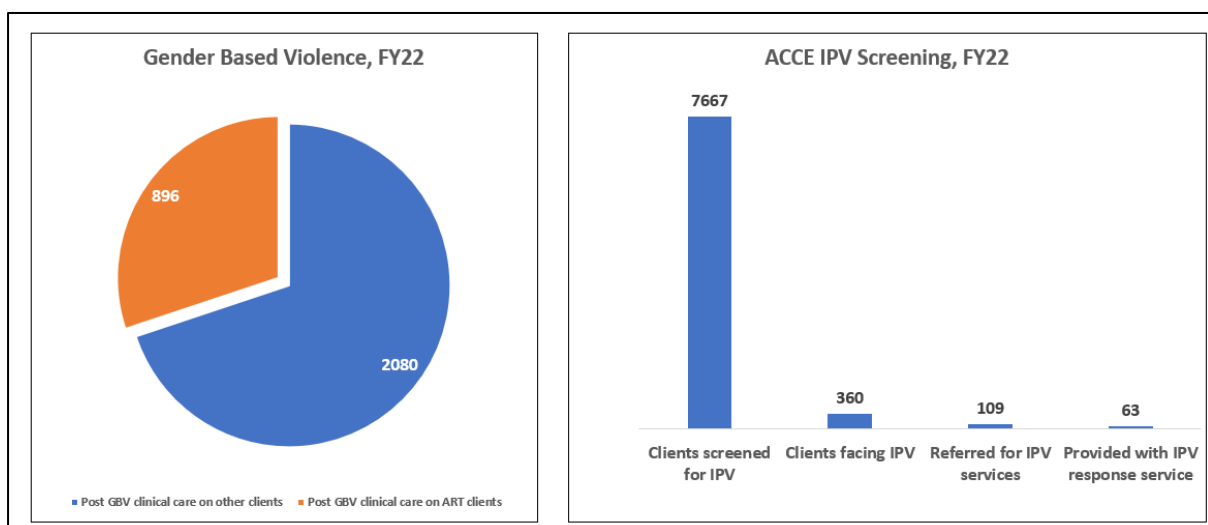


Figure 8: ACCE IPV and Gender Based Violence October 2021 – September 2022

3.1.5.2 Mental Health

Anxiety and depression are mental health problems that should be screened for in people living with HIV annually in line with the operation and service manual guidance. A total of 129,824 clients were screened for mental health in the period under review. Of the screened clients 4% (4,853) needed mental health services and only 32% of these received the services. Of those who received services, 49% were referred for further specialized mental health services (Figure 9).

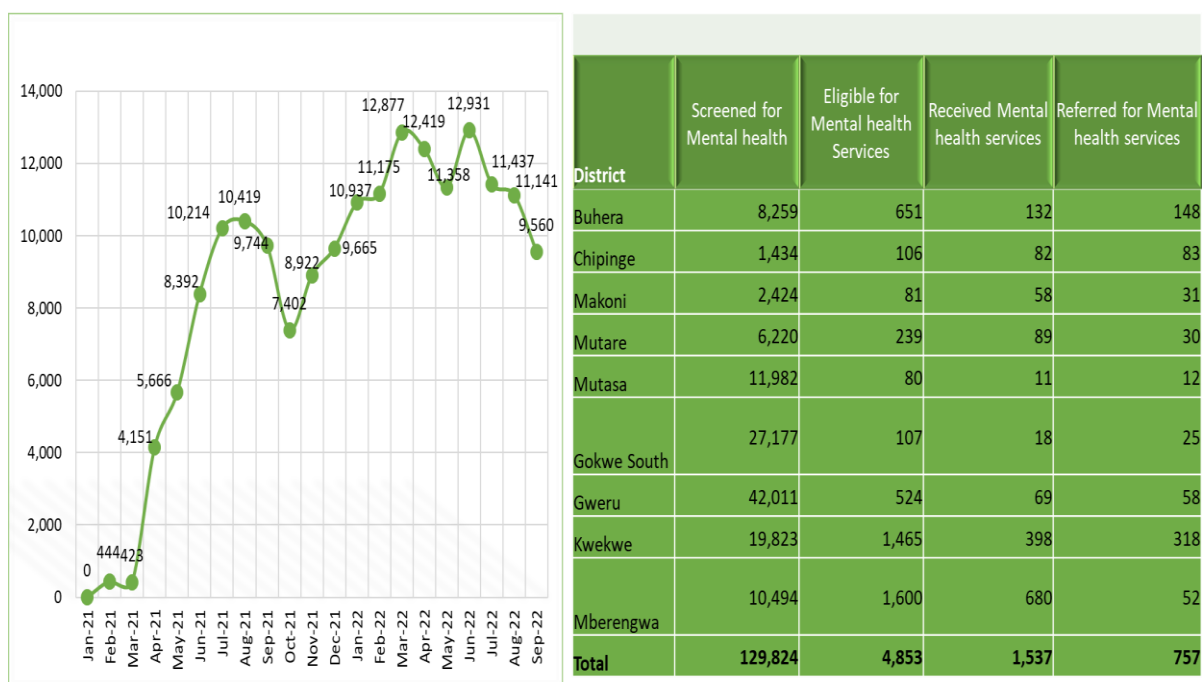


Figure 9: ACCE Mental Health Screening and Services October 2021 – September 2022

Documentation of mental health screening remains a challenge because of the unavailability of standardized registers. In addition, the referral pathways within the public sector are not supported. ACCE capacitated program staff on mental health screening through capacity building sessions, OJT, and mentorship. These will cascade the training to MOHCC staff as part of technical assistance to ministry of health.

4. To increase access and availability of quality, effective, targeted, and efficient HIV testing services for active case finding of the remaining undiagnosed PLHIV in implementing districts

To achieve greater levels of HIV diagnosis, the ACCE project has paid great focus on more efficient testing approaches leveraging on the successful strategies from previous projects. The targeted approaches to delivering the HIV testing services include index case testing of sexual and biological contacts, and self-testing. Under MOHCC guidance, the project introduced and continues to utilize the new HIV testing algorithm which improves efficiency in case finding of undiagnosed PLHIV.

4.1 HIV Testing Services

A total of 244,937 HIV tests were conducted in the period under review with facility testing making up the majority of these (98%). Despite the low coverage, community testing realized an impressive positivity rate of 31% due to the project's emphasis on HIV self-test distribution, targeted testing, and index case testing. The positivity rate at facility was 4.7% giving an overall positivity (facility and community) yield of 5% with 97% (12,278/12,668) linked to ART initiation (Figure 10). Clients not linked to care immediately as per the guidelines of the Test and Treat policy were due to TB

investigations and treatment or were acutely ill patients. The project has a standardized weekly cohort linkage analysis to ensure that clients are linked to care.

The project experienced some stock-outs of the HIV test kits, in particular INSTI, during quarter 3 and this negatively affected testing across the project. To address this challenge, we advocated for a revision of the testing algorithm by reverting to the old algorithm which does not require INSTI. This was done through the national AIDS and TB department and testing continued. The project also supported with test kits distribution when the INSTI test kits became available.

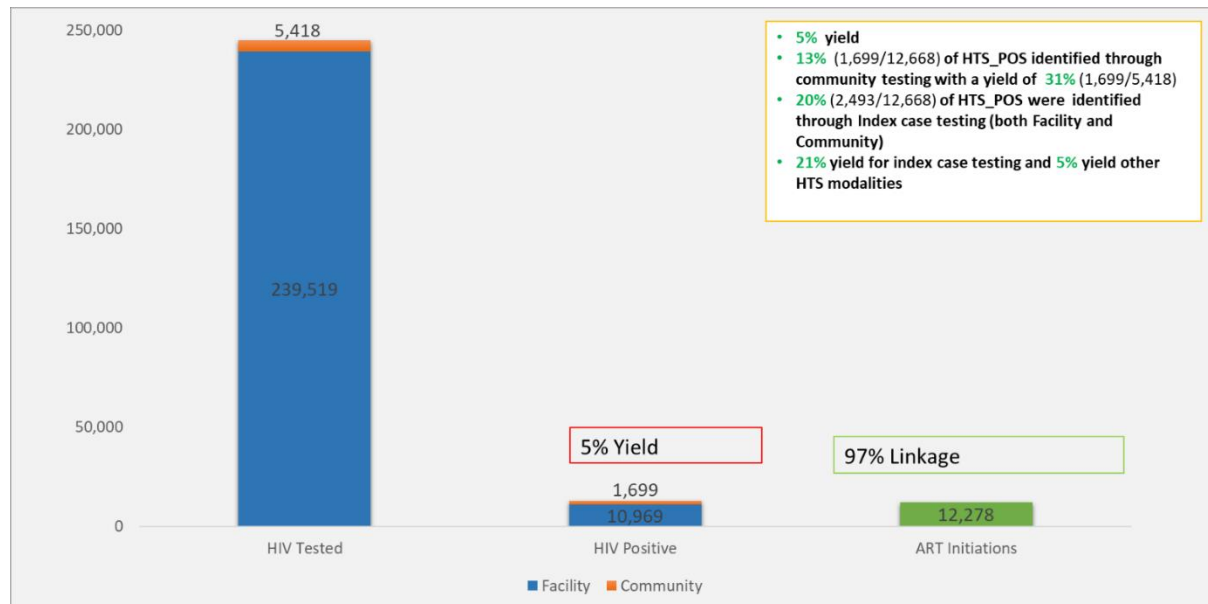


Figure 10: ACCE HIV Testing Services October 2021 – September 2022

4.2 Index Case Testing Services (Facility and Community)

Despite Index Case Testing (ICT) being the key strategy for realizing high yield within the ACCE project, only 20% (2,493/12,668) of clients that tested HIV positive were identified through Index case testing (both facility and community) against an expectation of at least 45% ICT contribution to HTS_POS. Overall, the ACCE project had a 21% yield rate for index case testing and 5% yield on other HIV Testing Services (HTS) modalities. An analysis of the ICT cascade indicates an offer rate of 75% with the highest offer rate among newly diagnosed clients of 85% (10,676/12,599) whilst the offer rates for defaulters and virally unsuppressed clients were 64% and 59% respectively (Figure 11). Significant missed opportunities were noted on contact tracing for clients with high viral load and defaulters coming back to care. In COP22, the project will improve offer rate for clients with high viral load through scaling up and strengthening of enhances adherence (EAC) clinics and embedding ICT within the standard operating procedures (SOPs) for high viral load management. We also noted that there were documentation gaps which also affected how the offer rate was being reported across the project sites and guidance on the reporting has been shared with the sub-national teams and mentorship and OJT will be prioritized on this. The acceptance rate was quite good at 92% but could be improved with improved counselling. The elicitation rate was at 1.5 contacts per index, and this is an acceptable ratio.

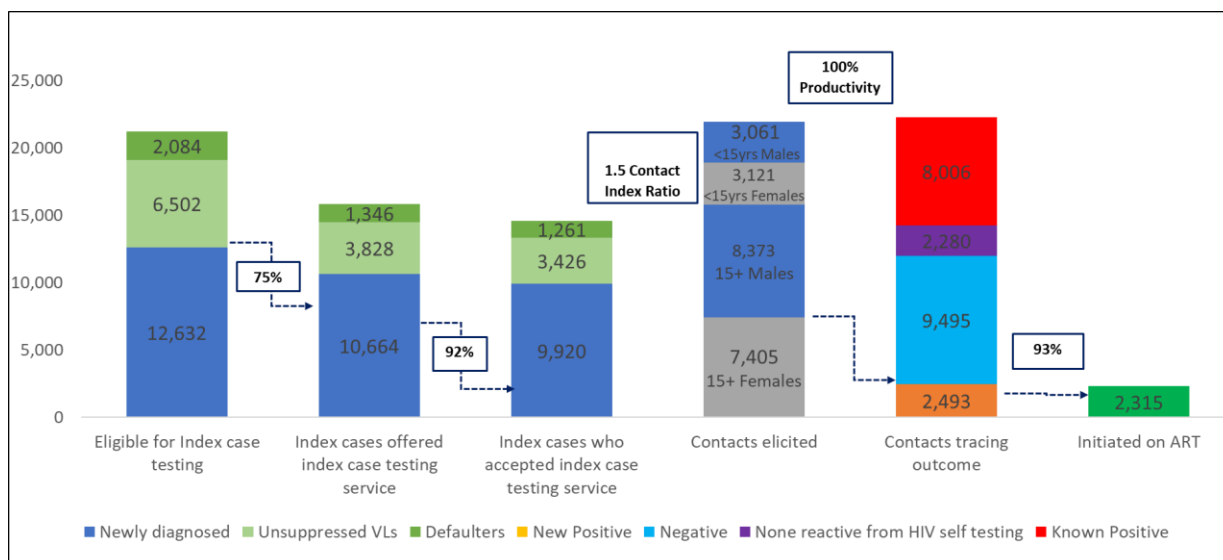


Figure 11: ACCE Index Case Testing Cascade October 2021 – September 2022

4.3 Quality Assurance for HTS

The project provided TA to MOHCC for the implementation of HIV testing quality assurance (QA) initiatives. The project facilitated competency assessments for HIV testing and is working closely with BRTI to ensure that all nurse testers at supported sites have a valid proficiency test. Currently only 58% of the ZHI ACCE testers have undergone proficiency testing as compared to from 42% in Q3 of this COP. Challenges have been noted around the availability of the panels shared by the lab for proficiency tests. It has been noted that the laboratory has been sharing inadequate panels. The project has also engaged MOHCC on this issue and we are hopeful that the situation will be rectified in COP22.

5. To ensure that newly diagnosed PLHIV are initiated on ART and that PLHIV are retained in care through provision of comprehensive HIV care and treatment services using evidence-based DSD models/ client-centered approaches.

5.1 Optimizing Linkage to ART

The ACCE project managed to surpass 95% ART linkages target in all districts in COP 21; Chipinge district achieved 100% ART linkage (Figure 12). In COP22, clients who were not linked to ART will be tracked and linked. Some missed opportunities were because of delays in initiating ART due to stock out of TB medicines for clients who tested HIV positive and had active TB disease. The stock out of TB medicines which occurred in quarter 3 has since been addressed and line listed clients were tracked for ART initiation. One key strategy that led to a sustained linkage above 95% across the year was the introduction of weekly cohort analysis of clients who would have tested positive in the previous week of the report. This assisted with ensuring that the project was able to account for all clients who test positive weekly.

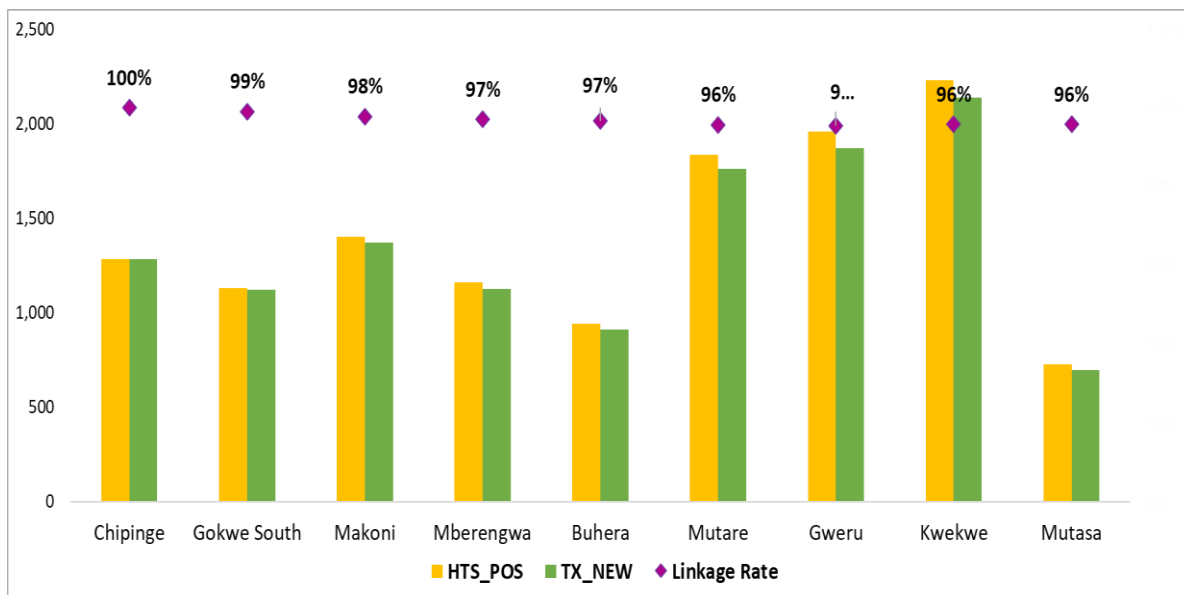


Figure 12: ACCE Linkage to ART October 2021 - September 2022

5.2 Differentiated Service Delivery (DSD) Models

There was a gradual increase in the proportion of ART clients in DSD models from 42% in October 2021 to 51% at the end of COP21. Implementation of DSD models by districts ranges from as high as 65% in Gweru to 39% in Makoni (Figure 13 and 14). Going into the second year of implementation, lessons will be drawn from districts such as Gweru that were able to scale up DSD to 65% and applied to districts with suboptimal performance such as Makoni. The project is using evidence from deep dives conducted to support the scale up of DSD models that have higher treatment continuation rates i.e., community ART refill groups (CARGs), Family Refill, and Adolescent Clinic, and those that are suitable and most practical given the context and setting. The rural communities registered higher numbers of CARGs than the urban communities that have the fast track as the most favorable DSD model.

Reasons for the low DSD coverages across the districts are poor documentation of enrolled clients, lack of appreciation of the advantages of DSD models by both clients as well as the healthcare workers. In COP22, we are expecting 80% of the PLWHIV in the PEPFAR supported sites to be in a DSD model. To achieve this, efforts will be made to close the information gap on the utility of DSD models for both healthcare workers (HCWs) and PLWHIV through capacity building for HCWs, health education for clients. The project will also support the printing and distribution of information, education, and communication (IEC) material to create appetite for DSD models for both HCWs and PLWHIV. We will also collaborate support from Zvandiri's Community Adolescent Treatment Supporters (CATS), we managed to set up support groups and implement dedicated clinics for adolescents. This will be strengthened in COP22 through collaboration with orphans and vulnerable children (OVC) partners especially in sites where the CATS are not present.

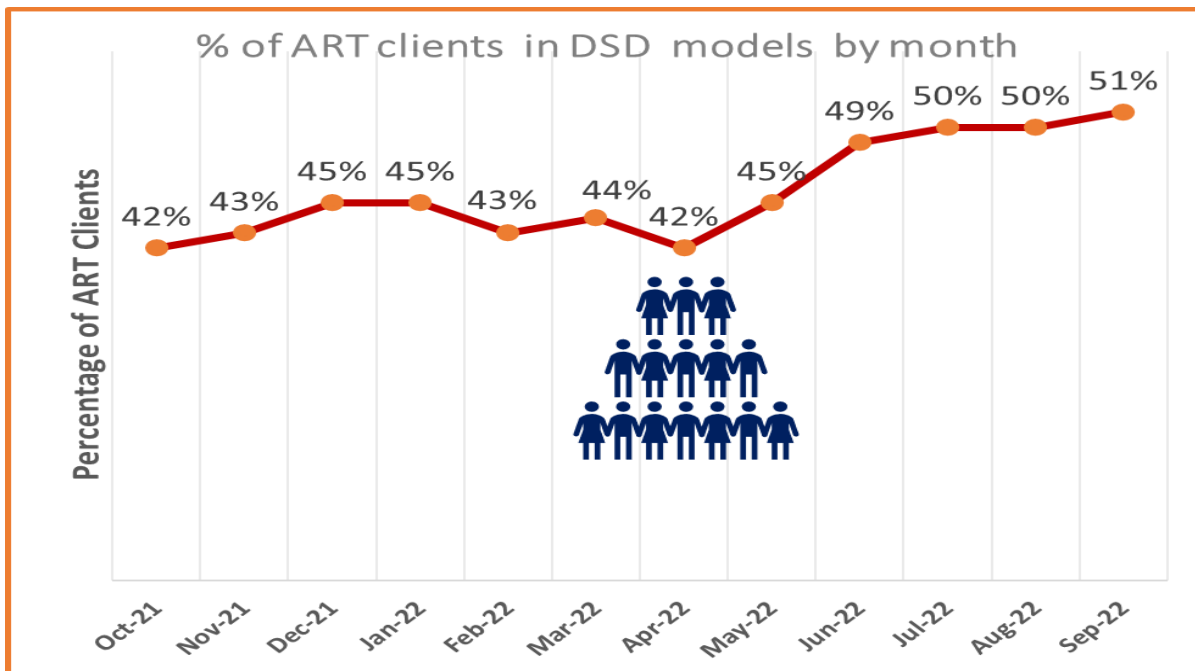


Figure 13: Percentage of ART clients in DSD models by month, October 2021 to September 2022

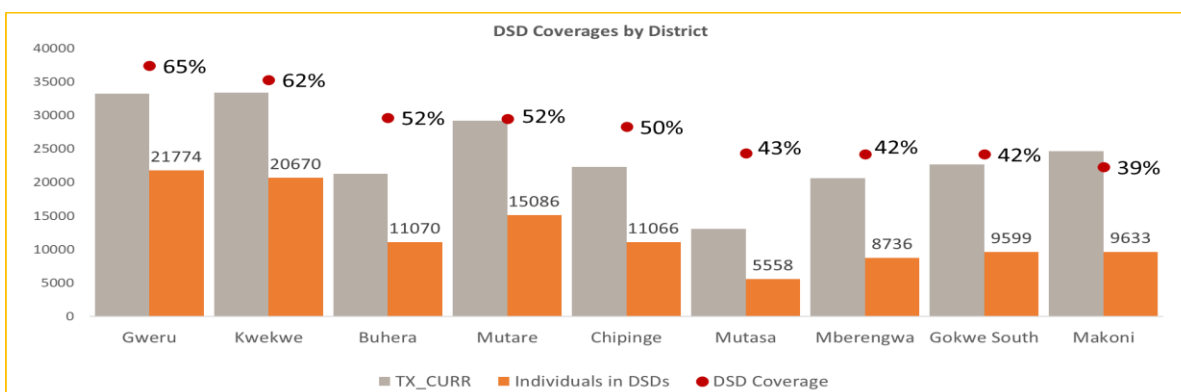


Figure 14: DSD Coverage by district (September 2022)

5.3 TLD transition

ACCE project is supporting sites to transition clients to the optimal Dolutegravir (DTG) based regimens such as TLD and ABC/3TC/DTG as recommended by MOHCC and WHO guidelines. All sites have at least one cadre trained on pediatric Dolutegravir (pDTG) to make sure all children living with HIV (CLHIV) weighing at least 3kg and older than 4 weeks are initiated or transitioned to a DTG based regimen. In COP21, the ACCE project supported MOHCC to transition children to DTG - based regimens by supporting capacity building of healthcare workers in both DSD and TA districts. As at the end of COP21, data on DTG-transition for the CAYPLHIV from the high-volume sites indicate a transition rate above 90% and this has also pushed the viral suppression from an average of 87% in December 2021 to 94% as at September 2022. In COP 22, the project will continue to support MOHCC to ensure ART optimization among all CAYPLHIV. As at end of COP21, we had zero clients on Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI) regimens in the supported sites.

5.4 Viral Load (VL) Service Uptake

The ACCE project has supported the MOHCC to ensure that clients have access to viral load and results are utilized timely. Figure 15 shows the quarterly viral load coverage performance during COP21. There was an improvement in VL coverage from 65% in Q1 to 70% in Q4 for DSD districts. When combined with the TA districts, the VL coverage improved from 55% in Q1 to 60% in Q4. Table 5 shows the disaggregated performance for both the DSD and TA districts. The performance in the TA districts remains low and the ACCE project will continue to make use of every opportunity available to support MOHCC to improve VL coverage in the TA districts firstly by ensuring complete reporting and secondly through mentoring on VL collection using the provincial review meetings and clinic laboratory interface (CLI) platforms.

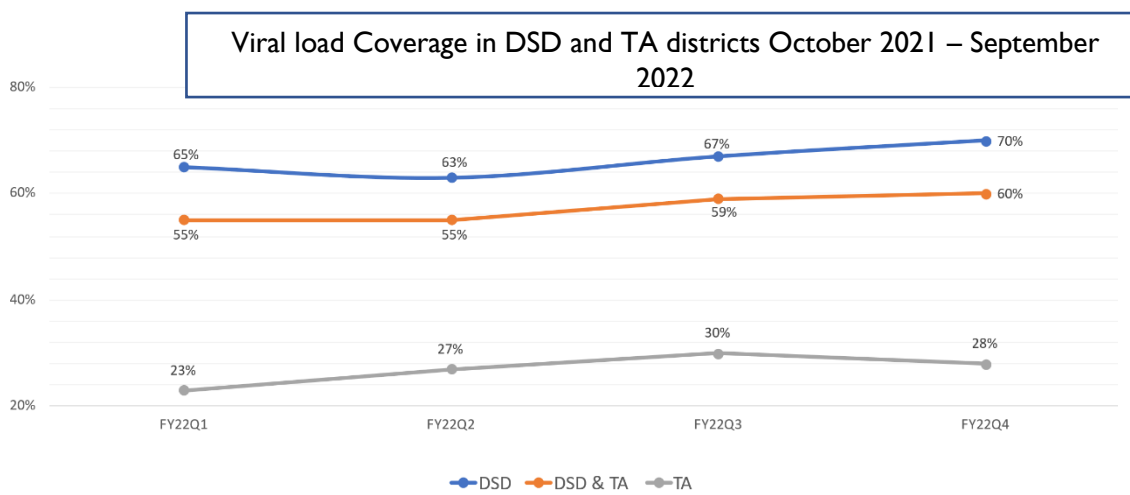


Figure 15: Viral load coverage in DSD and TA districts, October 2021 to September 2022

The ACCE project has also supported the utilization of POC viral load testing platforms in the two provinces with support for ordering and distribution of cartridges for the VL POC platforms. The POC VL model targets priority populations such as children, adolescents, pregnant and breastfeeding women. There was a steady increase in VL testing on POC platforms for pregnant and lactating women, CAYPLHIV and repeat VL for unsuppressed clients (Figure 16). The project will continue to monitor and strengthen utilization of the POC platforms through supporting commodity security and timely reporting for machine breakdown to reduce machine down time.

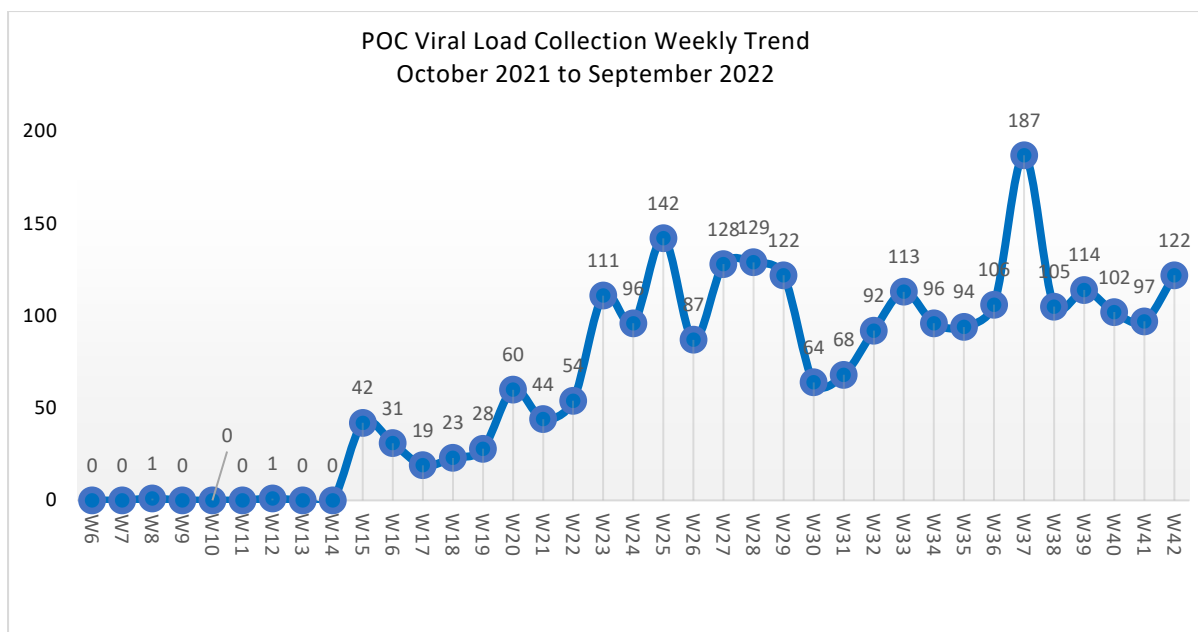


Figure 16 : Viral load testing on POC VL testing platforms for priority populations in the ACCE DSD districts, March 2021 – September 2022.

Whilst the VL coverage was at 70% in the DSD districts, the sites had collected 180,104 specimens which translates to 80% of the Q2 TX_CURR. From October 2021 to September 2022, a total of 18,008 results were missing, and this represents about 8% of the Q2 TX-CURR. Almost 50% of these results being for clients bled in Q1 and Q2 and the rest being for Q3 and Q4. Manicaland was the most affected, especially in Q2 where several specimens were transferred to the National Microbiology Reference Laboratory (NMRL) due to reagent stock outs. Several VL results from that period are missing.

As we closed out COP21, the laboratory information management systems (LIMS) were operating sub-optimally and negatively affecting the transmission of results to testing hubs and subsequently to facilities. This was affecting both the Manicaland and Midlands laboratories and this again resulted in specimens being referred to the NMRL lab leading to increased turnaround times for results. As of September 30, 2022, Victoria Chitepo Provincial Laboratory had a VL testing backlog of 1,868 samples whilst Gweru provincial hospital had 2,115 samples (Figure 17). The increase in backlog was attributed to the suboptimal performance of the LIMS software after the decentralization of LIMS capturing from the provincial lab to hubs. As the lab colleagues were working on upgrading LIMS, viral load samples were sent to NMRL for capturing and processing. To ensure follow up of these results, the project has committed to keeping track of all samples that will be processed outside the province in collaboration with BRTI so that these results translate into patient care. In COP 22 it is our hope that a lasting solution is found to address results transmittals challenges.

There were also missed opportunities for VL collections for clients presenting at the facilities, especially in tier 2 and tier 3 facilities. Moving into COP 22, we will support our district teams to be deliberate about planning for mentorship and support focusing on low performing sites through the DSD cluster nurses and the district mentorship teams. Identification of clients due for VL will be strengthened through use of a flagging system as well as strengthening the cohort filing system. In addition, the project is supporting design and implementation of continuous quality improvement (CQI) initiatives using the Plan – Do – Study – Act (PDSA) model. All Tier 1 and some Tier 2 sites have CQI projects focusing on optimization of VL testing. The project will continue scaling up and institutionalization of this approach to all sites in COP22.

Table 5: Viral Load Coverage & Suppression Rate, DSD & TA districts, October 2021 – September 2022

District	TX_CURR (Q2)	TX_PVLS (D)	Coverage	TX_PVLS (N)	Suppression Rate
Buhera	21,428	16,636	78%	15,721	94%
Chipinge	21,913	13,446	61%	12,901	96%
Makoni	24,434	16,218	66%	15,494	96%
Mutare	28,815	23,342	81%	21,876	94%
Mutasa	13,013	8,948	69%	8,599	96%
Gokwe South	22,714	13,513	59%	13,103	97%
Gweru	33,017	24,940	76%	24,265	97%
Kwekwe	32,707	22,654	69%	21,710	96%
Mberengwa	20,329	12,310	61%	12,007	98%
Chimanimani	9,874	3,291	33%	3,122	95%
Chirumhanzu	10,520	2,040	19%	1,871	92%
Gokwe North	8,759	2,877	33%	2,702	94%
Nyanga	8,267	1,905	23%	1,759	92%
Shurugwi	10,506	3,259	31%	3,018	93%
Zvishavane	14,958	4,349	29%	4,091	94%
DSD & TA	281254	169728	60%	162,239	96%

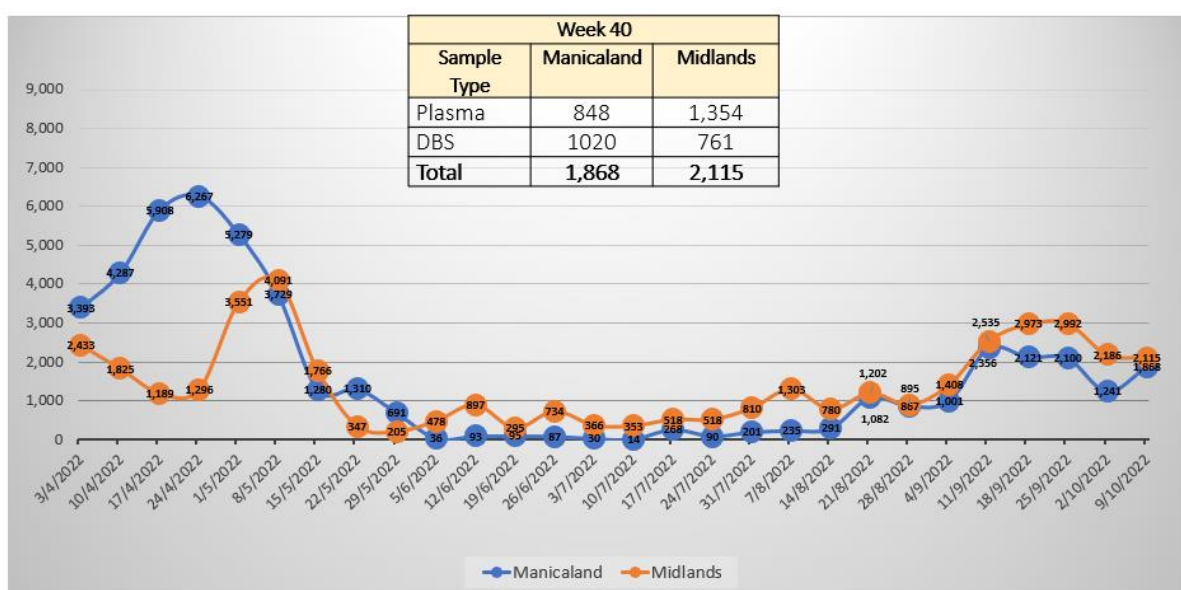


Figure 17: Lab Viral Load backlog clearing trends, October 2021 to September 2022

5.5 Continuity of Treatment

The ACCE project in FY22 has shown growth on the total number of clients on ART from October 2021 to September 2022 with a net new increase of 6,137 PLHIV (Figure 18).

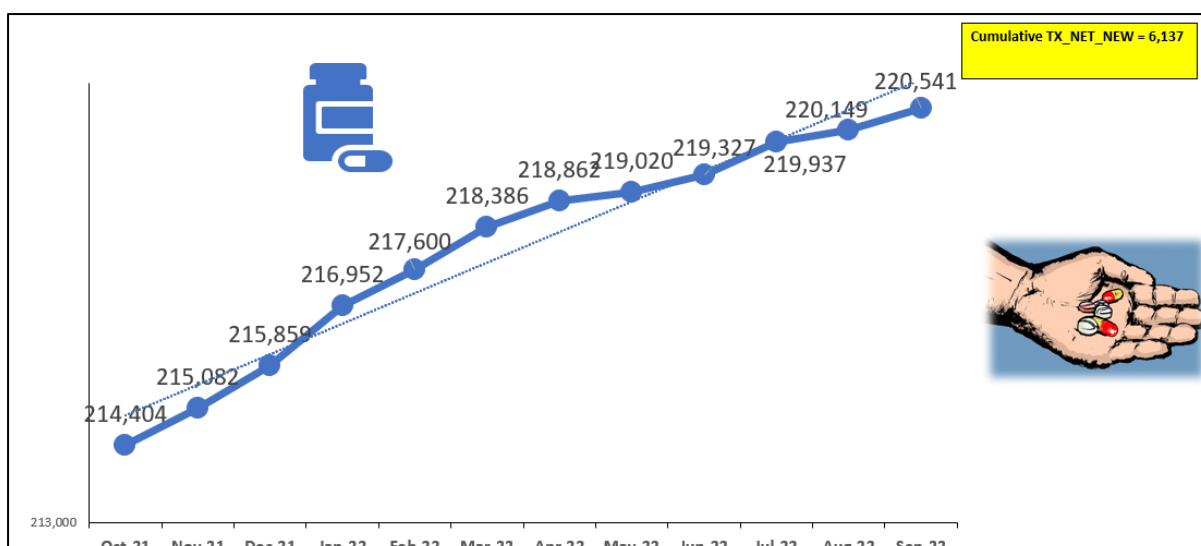


Figure 18 : ACCE TX_CURR Trendline October 2021 - September 2022

Most of the clients that were reported to be on ART in Midlands and Manicaland were on 3-5 months MMD (76%) followed by 6 months MMD (18%). Having learnt from experiences associated with which include improved retention and viral load suppression, the project made deliberate efforts to scale-up the MMD innovations. However, the 6MMD was sometimes affected by limited medicines supply resulting in most facilities resorting to the 3-5 MMDs. Mutasa has the highest percentage (38%) of their clients on 6MMD when compared to the other 8 ACCE districts (Table 6). Moving forward, ACCE has prioritised supply chain management capacity building for HCWs to ensure commodity security to optimize 6MMD. However, information from the directorate of pharmacy services (DPS) indicates that the national stocks are not yet at the level to accommodate 6 MMDs. Advocacy in MMDs will continue in COP22.

Table 6: Distribution of MMD by district, October 2021 – September 2022

PLHIV in care currently receiving ART (TX_CURR)							
	Clients on Less than 3 months ARV		Clients on 3-5 months' supply of ARVs		Clients on 6 months or more of ARVs		Total TX_CURR
Buhera	1,749	8%	19,027	89%	540	3%	21,316
Chipinge	441	2%	18,748	84%	3,148	14%	22,337
Makoni	593	2%	20,945	85%	3,153	13%	24,691
Mutare	1,826	6%	19,576	67%	7,812	27%	29,214
Mutasa	802	6%	7,276	56%	4,968	38%	13,046
Gokwe South	2,818	12%	13,331	59%	6,506	29%	22,655
Gweru	1,833	6%	25,729	77%	5,690	17%	33,252
Kwekwe	2,195	7%	27,166	81%	4,064	12%	33,425
Mberengwa	1,716	8%	14,810	72%	4,079	20%	20,605
Total	13,973	6%	166,608	76%	39,960	18%	220,541

At the end of FY22 Q4, Midlands and Manicaland DSD districts had a total TX_CURR of 220,541. Potentially the TX_CURR could have been at 236,158 from additions through new initiations, return to care of the interruptions in treatments clients and transfers-ins. As presented in water fall analysis

(Figure 19), there were 8,607 documented patient transfers outs, 1,596 deaths and an interruption in treatment of 5,350.

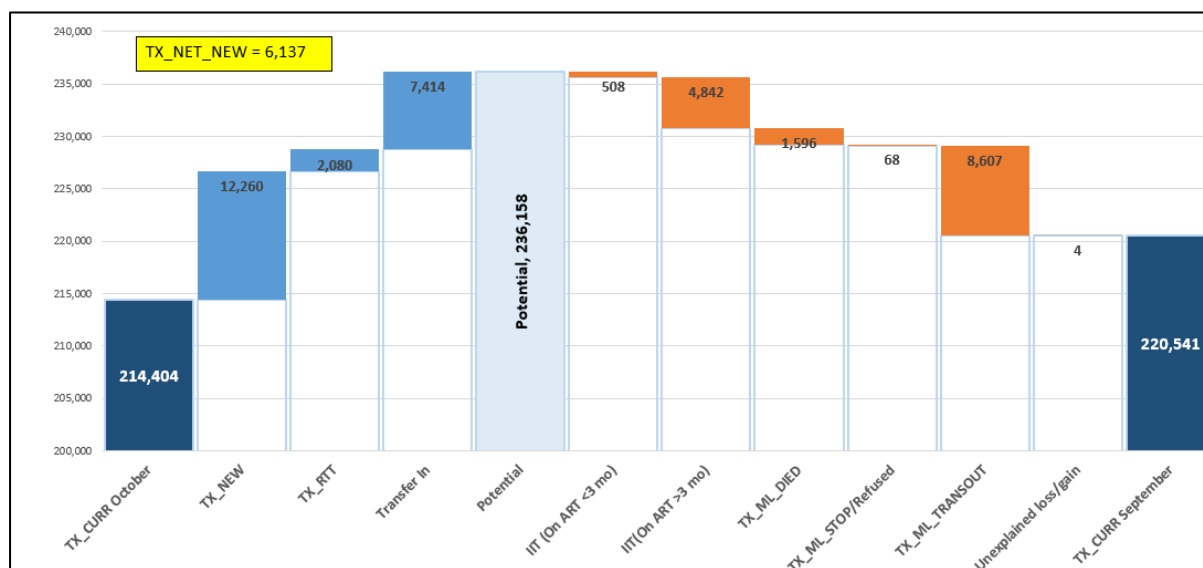


Figure 19: ACCE TX_CURR Waterfall Analysis October 2021 - September 2022

To minimize losses and improve continuity of treatment (CoT) in the supported sites, the project will support the following areas.

- Strengthen the capacity of expert clients to be able to support sites with defaulter tracking, peer support for clients who reengage after interrupting treatment. The project will utilize the MOHCC curriculum and incorporate the Flip the Script (FtS) initiative to address treatment literacy.
- Scale-up of advanced HIV disease management through capacity building of HCWs and supporting commodity ordering and distributions.
- Strengthening peer support by assigning every newly diagnosed client to an expert client who will support them through the first six months of treatment ensuring access to all key interventions (TPT, cervical cancer screening and VL).
- Support clients re-engaging in care through provision of clinical and psychosocial supports to ensure that they remain in care.
- At project level we will also introduce retention meetings at community level, district level and the overall project. These meetings are meant to enable the project teams to maintain the retention indicators on the radar.

5.5.1 ART Defaulter tracking

During the period under review, the ACCE project continued with implementation of defaulter tracking activities in Manicaland and Midlands Province to facilitate continuity of treatment and minimise treatment interruption. A cumulative total of 51,181 defaulters were registered from the 373 supported facilities. Through the collaborative efforts of the ACCE project supported by Clinical Referral facilitators (CRFs), Outreach Workers (OWs) and Community Nurse Testers (CNT), a total of 50,791 (99%) were tracked. Out of the 31,264 identified as true defaulters, 24,374 (78%) were returned to care (figure 20).

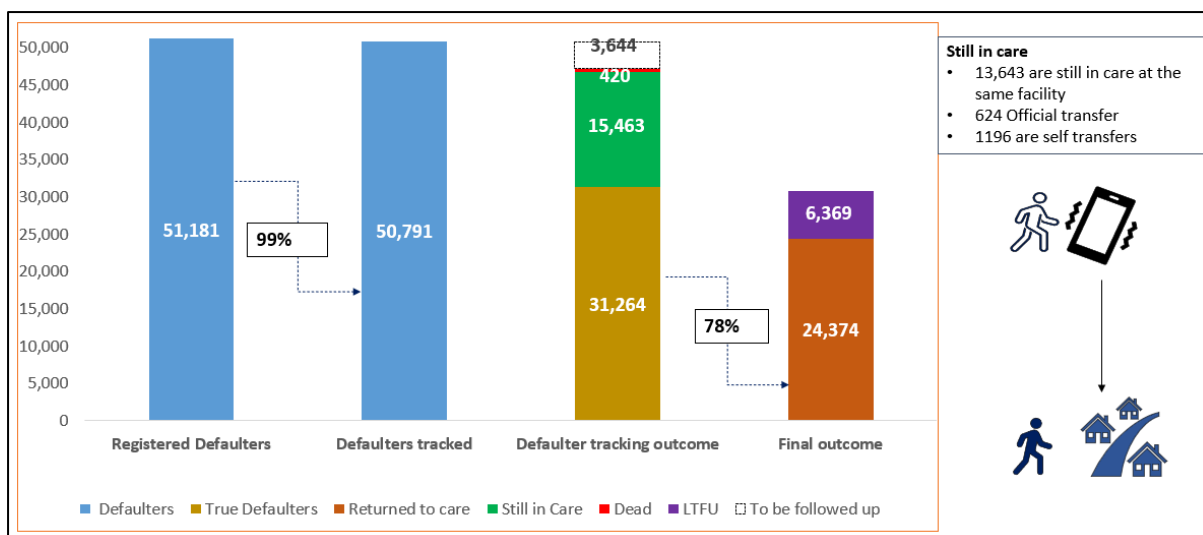


Figure 20 : ACCE ART Defaulter Tracking Cascade October 2021 - September 2022

About 30% (15,463/51,181) of the clients registered as defaulters were upon follow-up noted to be still in care with 13,642 still in care at the same facility, 624 official transfer-out and 1,196 self-transfers. The main reason for the high number of clients tracked as missed appointments when they are still in care is documentation of the visits in the client care booklets. This has been mainly due to the high Human Resources for Health (HRH) attrition rate and low staff morale within the MOHCC workforce. Taking this into consideration, the project will work closely with MOHCC leadership at provincial and district level to initiate a discussion on the extent to which lay cadres (who are already supporting documentation in some sites) can be allowed to document in the patient care booklets especially for clients on DSD models. With continued mentorship on correct use of the appointment system and linkage to the defaulter tracking registers, the project has seen a gradual decrease in the number of clients tracked and are still in care from 38% in FY22 Q1 to 24% in Q4 in FY22Q4 (figure 21).

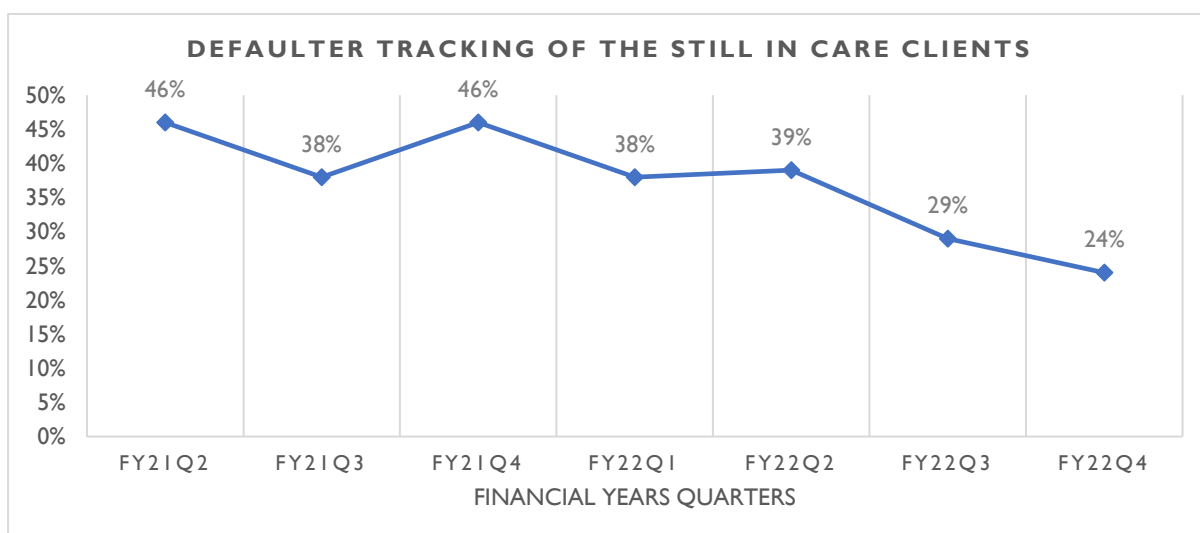


Figure 21: Trendline analysis of defaulter tracking for the still in care clients.

The ACCE project (Figure 22) improved on declaring the IIT from FYQ1 to FYQ4, however there was a decrease on the return rate on these IIT as the numbers were increasing. The project has planned deep dives at selected sites to understand this anomaly and come up with evidence – based interventions to address this. Meanwhile efforts to address this will be implemented and these include refresher trainings for the HCWs and expert clients (CRF, OW and CATS) in the utilization of the appointment diaries and the documentation of the defaulter tracking register with fidelity ensuring that outcomes are also documented. Concerted efforts to track clients by both phone and home visits will be implemented to try and improve the rate of return of our clients back into care.

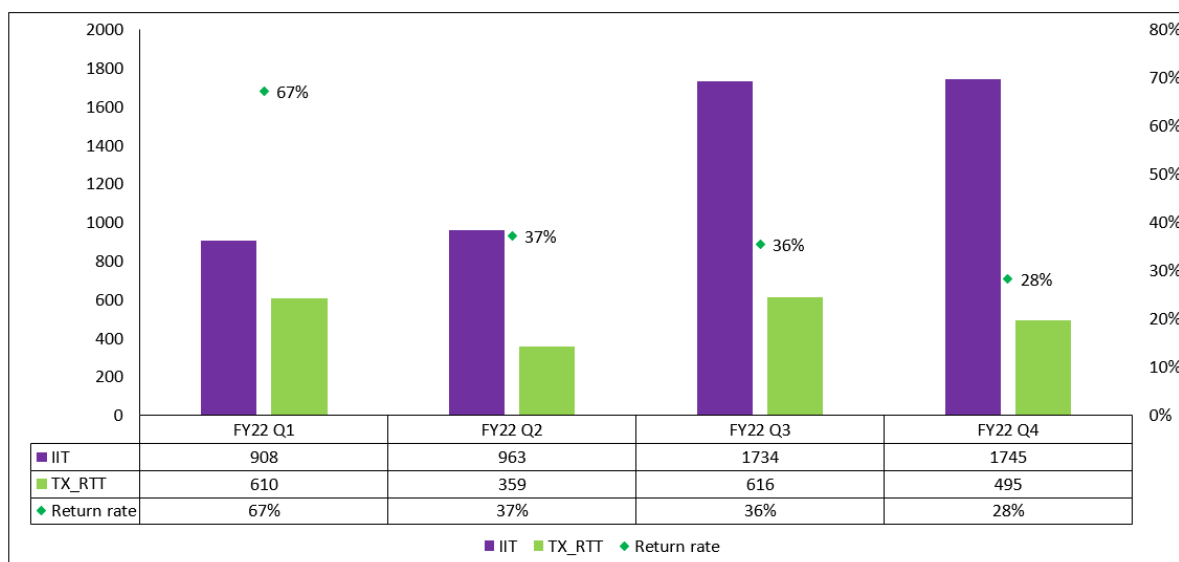


Figure 22: ACCE ART IIT and TX_RTT Monitoring, October 2021 - September 2022

5.5.2 Advanced HIV Disease

The ACCE project started implementing Advanced HIV Disease (AHD) support in August 2022. This was after we supported the capacity building of both MOHCC and project staff on AHD packages of care including diagnostics. Figure 23 shows access to CD4 testing within the trained sites which are predominantly high-volume sites. Clients eligible for CD4 testing were drawn from the newly diagnosed, those coming back to care after interrupting treatment for at least 90 days and those with confirmed and suspected treatment failure. During the two months of implementation in COP21, we managed to support access to CD4 testing for 89% of the eligible clients and of those tested, only 77% received results and of the results received 42% had a CD4 count less than 200 cells/ microliter. Gaps in access to CD4 testing are attributed to reagents unavailability and machine breakdowns. We have continued to engage the laboratory supply chain to support ordering and distribution when commodities were available. The gap in the AHD commodities is that the commodities are still being ordered centrally and are not being stored at the sub-national levels and we have recommended for decentralization of these commodities so that they are kept closer to the users and beneficiaries. To address the challenges of CD4 testing on conventional platforms where only 76% of the results were received, we have engaged the lab to order the POC Visitect CD4 platform which can be performed the non-lab personnel reducing the TAT of results and thus improving result utilization. The supply chain specialists have indicated that the country will be receiving a shipment of the Visitect during the first quarter of COP22.

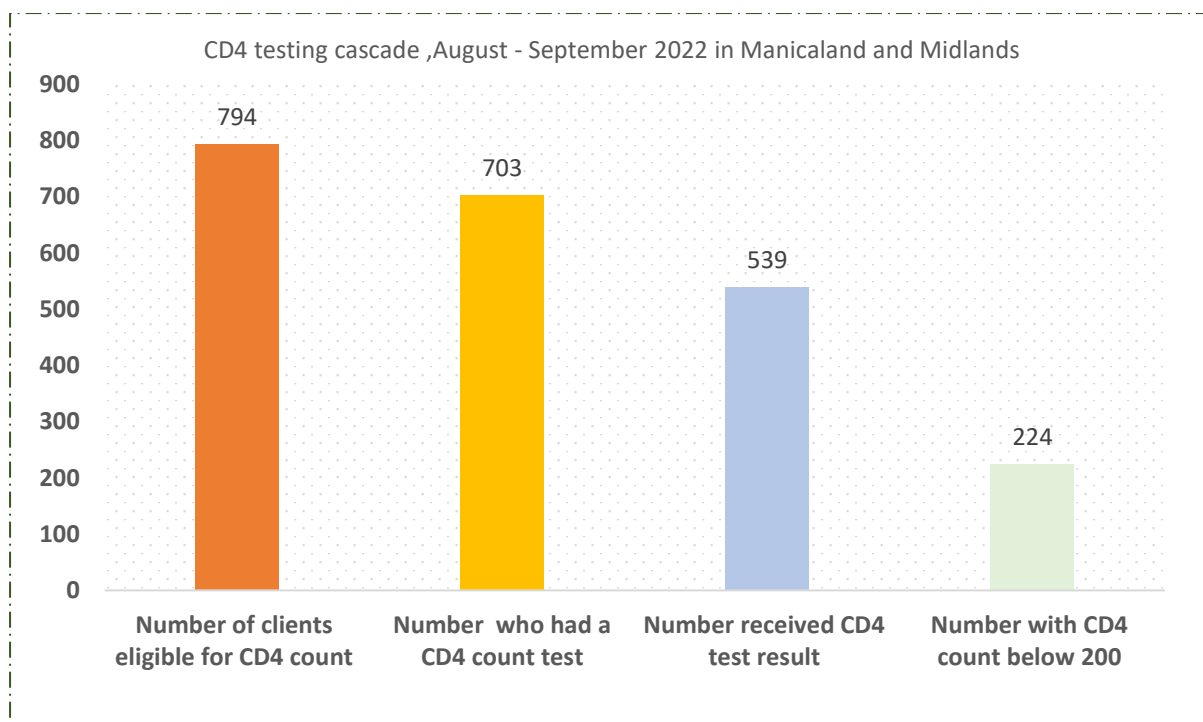


Figure 23: CD4 testing cascade for diagnosis of advanced HIV disease

Of the clients who had a CD4 test below 200 cells / microlitre, 90% and 95% had a serum cryptococcal antigen (CrAg) and TB Lipoaribomannan (LAM) test done respectively, and we managed to diagnose nine cases of cryptococcal meningitis disease and seven of the nine were initiated on cryptococcal meningitis disease whilst two died before treatment initiation (figure 24). Of the clients who had a TB LAM done, we managed to diagnose 39 cases, and these were all initiated on treatment (figure 25). Of note is during quarter 3, there was a national stock-out of adults TB medicines which lasted for more than a month. We supported redistribution of the medicines, but we still had clients who could not be initiated on treatment during the period. However, when the medicines became available, we managed to collaborate with the TB officers and ensure that the clients were initiated on treatment.

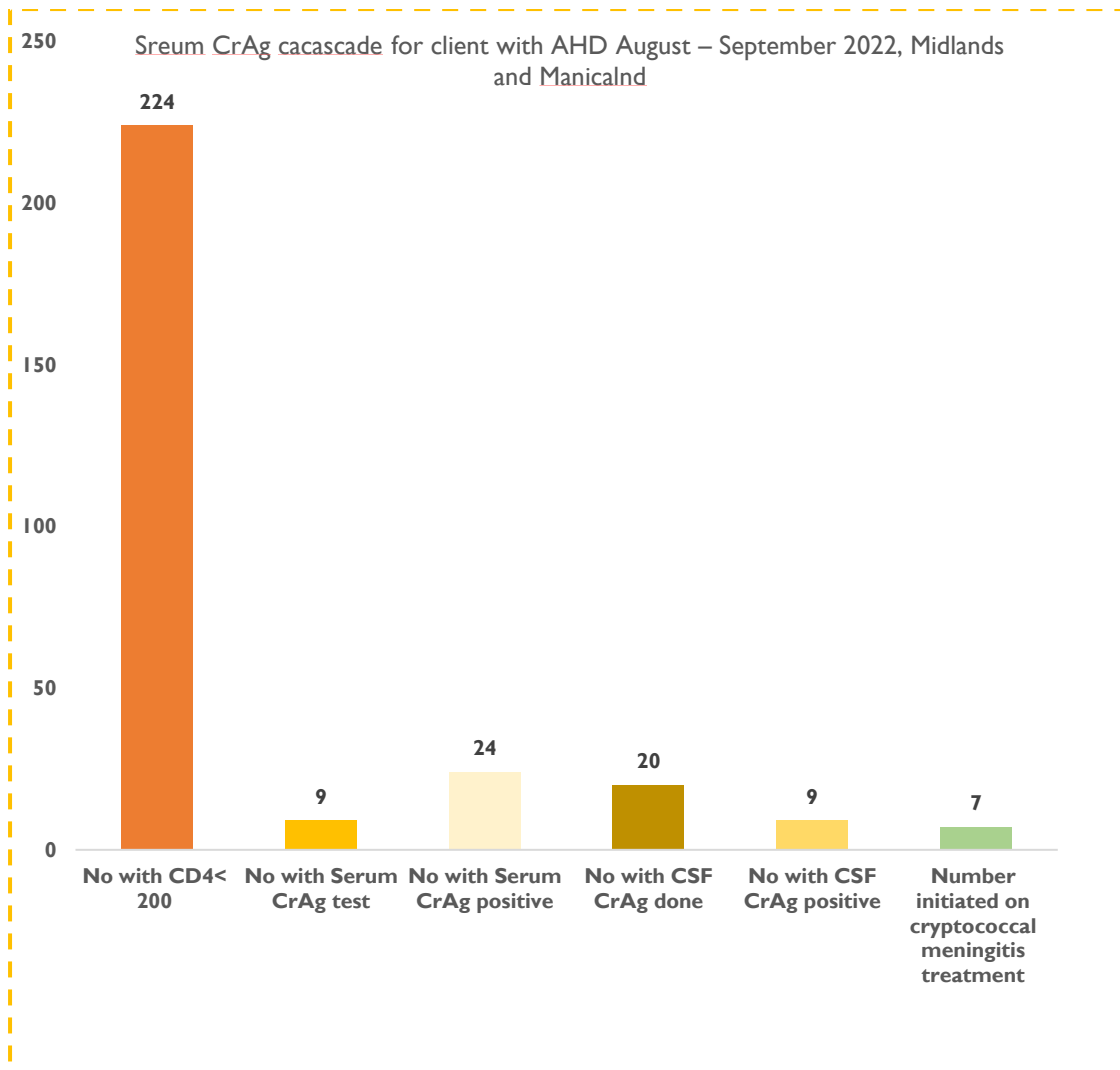


Figure 24: Cascade for serum CrAg and diagnosis of cryptococcal meningitis in Manicaland and Midlands provinces, August - September 2022

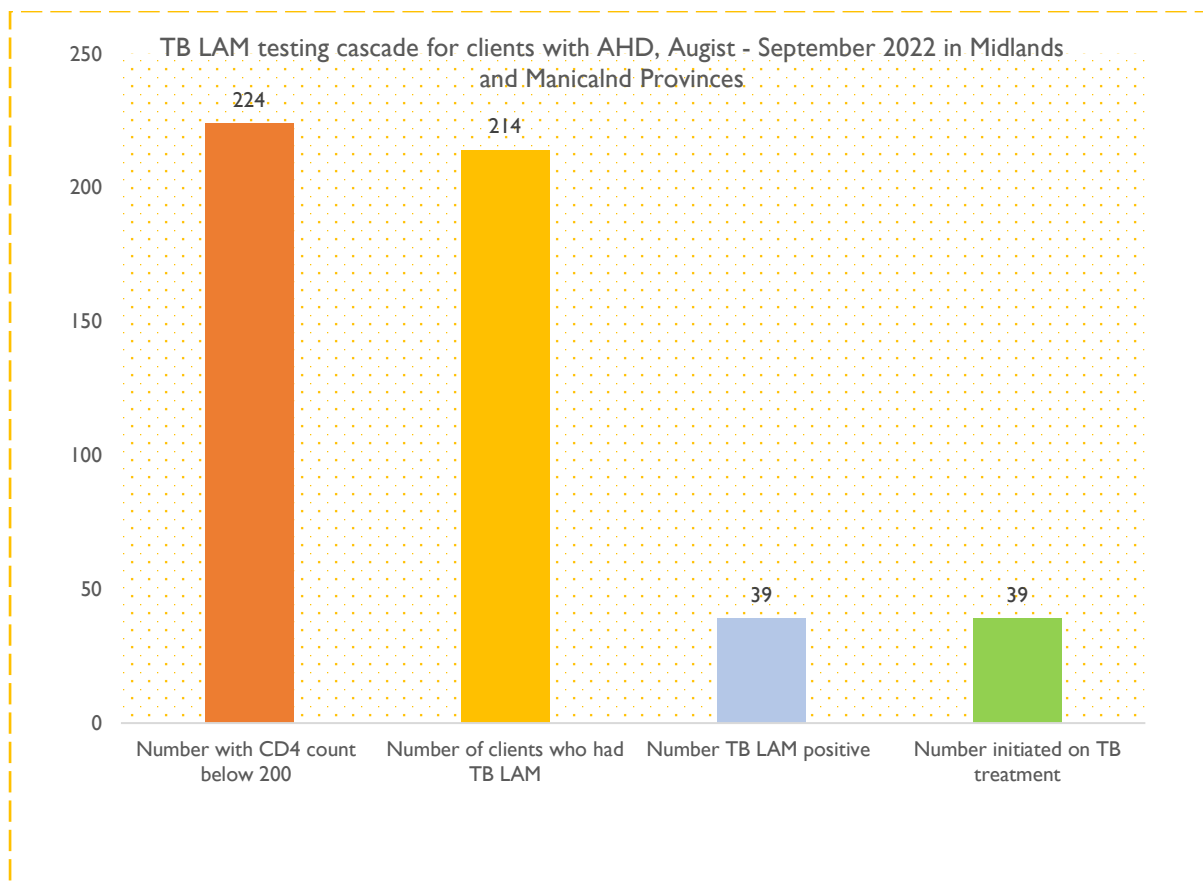


Figure 25 : Urinary TB LAM testing cascade and diagnosis of TB in AHD, Manicaland and Midland Province, August – September 2022

5.5.3 Green Book Transitioning

Currently 74% of the clients on ART have transferred to the new version of the 2021 green booklet. This is against a target of 100% by June 2022 (table 7). The low performance is mainly attributed to the tier 2 and tier 3 sites where we do not have a footprint daily. In COP22, the project will ensure enhanced supported to all sites through the DSD cluster nurses who will be responsible for a cluster of facilities in a district.

Table 7: ACCE Green book transition, October 2021 – September 2022, ACCE DSD districts

District	Sept TX_CURR	Total number of clients transitioned to new OI ART care booklets to date(Cumulative, W41 Oct)	Proportion
Buhera	21,316	20,193	95%
Chipinge	22,337	18,978	85%
Makoni	24,691	20,731	84%
Mutare	29,214	27,650	95%
Mutasa	13,046	12,777	98%
Gokwe South	22,655	18,048	80%
Gweru	33,252	23,131	70%
Kwekwe	33,425	23,562	70%
Mberengwa	20,605	17,171	83%
Total	220,541	182,241	83%

5.5.4 HIV/TB Integration

The project supported TB Preventive Therapy through supporting ordering and distribution of TPT medicines across the 2 provinces, both INH and 3 HP. The project team took a leading role in capacitating the ACCE project officers, MOHCC district leadership and facility clinicians in the use of the shorter and less frequent 3HP regimen. The introduction of 3HP resulted in a significant increase in both 3HP initiation and completion rates across the 2 provinces. Midlands has been slow to scale up 3 HP with the provincial leadership pushing for the districts to exhaust isoniazid (INH) stocks (expiring April 2023) first before moving to 3HP. However, the acceptance of INH is low even among clinicians as demonstrated by the low TPT initiations in sites with predominantly INH. Although a phased approach was adopted in the introduction of 3HP, discussions are still underway with the Midlands provincial leadership particularly, to increase the 3HP sites and at least approach the national target of 70% sites offering 3HP by end of Q1 of COP22.

Mutasa and Chipinge districts were able to achieve their annual target with a cumulative achievement of 114% and 113% respectively. Mutare, Buhera and Makoni districts were all above 80% achievement while a significant improvement was noted in Mberengwa district which closed the year at 77% TPT coverage. Districts that have had a rapid scale up of 3HP (Chipinge, Mutasa and Mutare) have shown improvement in their achievement towards TPT targets. Through the daily situation room meetings, district coordinators with support from the District Health Executive (DHE) worked closely with poorly performing sites and this contributed to the improvements noted in Manicaland.

Table 8: Performance against annual target by district

Started on TPT				
District	Annual Target	Started on TB Preventive Therapy (Including TPT)	Started on 3HP	% Achievement towards TPT Target
Buhera	5903	4842	1445	82%
Chipinge	5560	6293	3298	113%
Makoni	9218	8371	1938	91%
Mutare	9463	8917	3775	94%
Mutasa	3263	3718	965	114%
Gokwe South	7266	3884	1439	53%
Gweru	8990	5082	1760	57%
Kwekwe	10535	6028	2246	57%
Mberengwa	5220	4004	1559	77%
Totals	65418	51139	18425	78%

The TPT completion rates for the project for clients initiated on TPT during the period October 2021 to March 2022 were above 95% in all the nine DSD districts. This is a significant improvement from quarter 3 of COP21 where the project had an overall completion rate of 89%. Strategies to improve completion of TPT were mostly centered on ensuring documentation of the source documents and these are the client care booklets.

Table 9: TPT completion rate in the ACCE districts October 2021 - September 2022

TPT Completion			
District	Started on TPT (Oct 2021 to Mar 2021)	Completed TPT (April to Sept 2022)	% TPT Completion
Buhera	4,514	4,502	100%
Chipinge	2,039	2,007	98%
Makoni	4,857	4,857	100%
Mutare	7,087	7,034	99%
Mutasa	2,087	2,082	100%
Gokwe South	2,150	2,139	99%
Gweru	3,551	3,545	100%
Kwekwe	2,723	2,887	106%
Mberengwa	2,284	2,246	98%
Totals	31292	31299	100%

The project recorded a TB_STAT and TB_ART coverages of 94% (Figure 28). On TB_STAT, five out of the nine districts were above 95% whilst Chipinge Gokwe south and Mberengwa were above 90% but below 95%. Kwekwe districts was the lowest at 87% (table 10). Reasons for the poor performance were attributed to gaps in documentation especially among clients who would have been tested within three months before starting TB treatment. Sub-optimal performance on TB_ART coverage was partially attributed to stock-outs in TB medicines in quarter 3 of COP 21 which led to delays in ART initiation as clients awaited TB medicines. Again, as the TB medicines became available and clients eventually initiated on ART, there was a gap in ensuring that the ART initiations were

updated in the TB registers. Disaggregation of the data by site level has been done and the ACCE technical teams are supporting the sites to ensure documentation as appropriate. With this exercise, we anticipate closing the gap by the end of quarter I of COP22. The project will strengthen this program area by supporting documentation in real time.

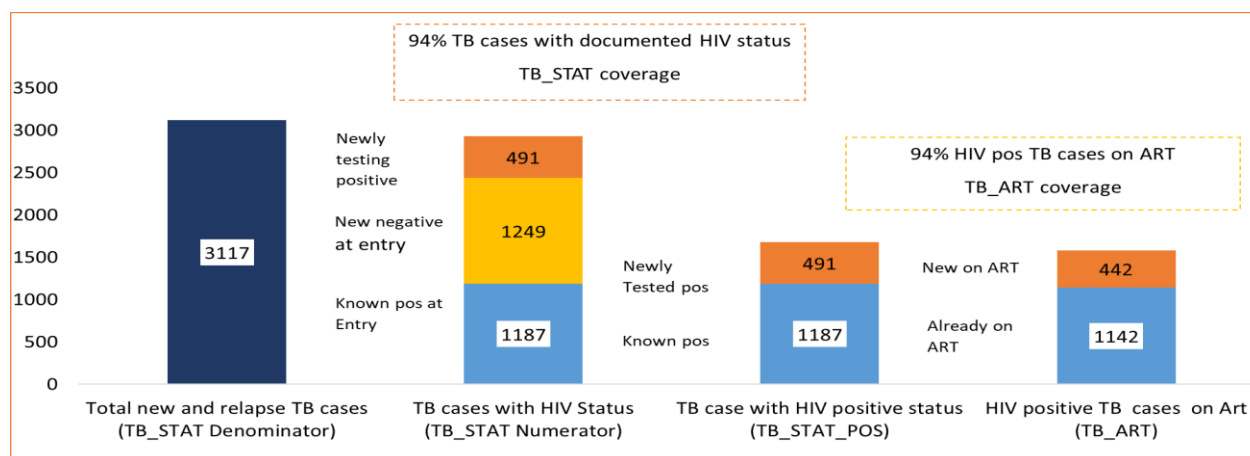


Figure 26: TB_STAT and TB_ART Cascade (October 2021- September 2022)

Table 10: TB_STAT and TB_ART Cascade by District (October 2021 - September 2022)

District	Total New and relapsed TB cases registered	TB patients newly testing HIV positive	TB patients testing HIV negative	TB patients presenting with an already known HIV positive status	% TB STAT COVERAGE	Registered TB clients who are already on ART	TB clients newly initiated on ART	% TB_ART COVERAGE
Buhera	306	35	156	113	99%	114	36	101%
Chipinge	432	55	246	105	94%	105	52	98%
Makoni	186	17	70	99	100%	84	27	96%
Mutare	302	77	75	135	95%	135	64	94%
Mutasa	110	18	37	53	98%	49	17	93%
Gokwe South	270	29	130	95	94%	93	27	97%
Gweru	509	96	196	207	98%	188	87	91%
Kwekwe	789	138	280	269	87%	267	114	94%
Mberengwa	213	26	59	111	92%	107	18	91%
Totals	3117	491	1249	1187	94%	1142	442	94%

5.5.5 Cervical Cancer Screening and Treatment

Figure 28 shows cervical cancer screening trends during COP21. The project surpassed the target throughout the year except in December 2021 and September 2022. During COP21, 50,356 (114% of annual screening target) women living with HIV aged 25-49 years were screened for cervical cancer through visual inspection with acetic acid and cardiography (VIAC) and human papilloma virus Deoxyribonucleic acid (HPV DNA) testing. A total of 1,811 clients screened VIAC positive giving a yield of 4%; 1,870 clients (103%) with precancerous lesions received treatment (Figure 29). This includes clients who screened VIAC positive and missed treatment opportunity in the previous reporting period and were tracked and offered treatment in the period under review. A deep dive conducted in Q2 showed that 43% of VIAC positive clients received treatment on the same day, and 77% within the recommended 30-day period. However, the 6-month post-treatment was 3.8%. The project will optimize post-treatment coverage through enhanced tracking of clients by utilizing both facility and community structures. The project will also strengthen the follow-up of clients with suspicious in COP22 to ensure completion of the referral and access to treatment.

In quarter 4 of COP 21, the project engaged a consultant to evaluate the quality of the VIAC program and to set up a quality control program for the project based on the gaps identified. The key findings from the consultancy were.

- Inadequate or poor-quality equipment such as (examination couches with no lithotomy poles, poor lighting) which negatively affected the quality of the images taken.
- Low concordance rate of the Loop Electrosurgical Excision Procedure (LEEP) done with histology results. For example, only 50% of the LEEP done in Mberengwa were positive for high-grade lesions and this indicates that only half of the clients required treatment.
- Human resources gap due to high rates of attrition of HCWs in the public sector.

To address these gaps the project will.

- Strengthen the quality control implementation at all levels and with increased frequency. Already a virtual platform which provides real time support to HCWs is now in place and images can be discussed in that platform.
- Put in place a verification layer at provincial level to ensure that we are not over-treating clients especially with LEEP. This will be done by the provincial gynecologist who will look at the VIAC images first before a client has a LEEP done.
- Continue with capacity building to address the human resource gap but also strengthen the outreach model of care so that more clients may be reached. We will also advocate for more sites to implement HPV DNA PCR testing as this has significant potential to reduce the number of clients requiring VIAC.
- Continue to support commodity ordering and distribution by working closely with the supply chain partner.

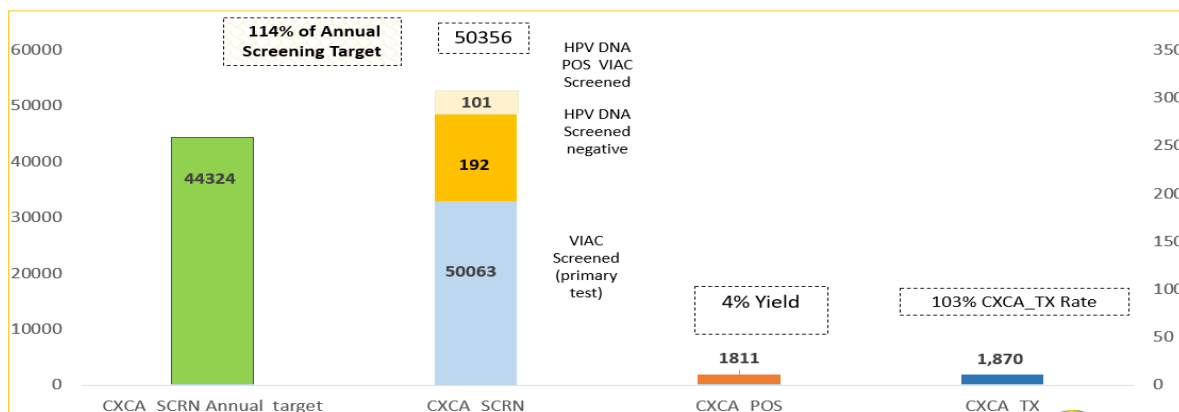


Figure 27: Cervical Cancer Cascade for Women on ART (25-49) for October 2021 - September 2022

During the period under review, the program implemented cervical cancer screening in 20 select sites in Makoni district using HPV DNA testing as the primary screening test followed by triage through VIAC for those testing HPV DNA positive and providing treatment if indicated. HPV DNA sample collection commenced in June 2022 (week 24). Full-scale implementation was affected by the inconsistent supply of sample collection kits and long intra-laboratory turnaround time. Of the 541 HPV DNA samples collected, 344 (63%) results were received. Of these, 152 (44%) were positive and were all referred for VIAC. 106 (70%) were linked to VIAC. HPV DNA testing enabled coverage of remote sites and through self-collected samples which can be distributed by less skilled health care workers, screening can be provided daily compared with VIAC where screening would only occur

once a month through outreach. However, leakages along the cascade will need to be closed. The Collaboration Learning and Adapting (CLA) team will be supporting a deep dive to better understand determinants of leakages and come up with interventions to close the gaps.

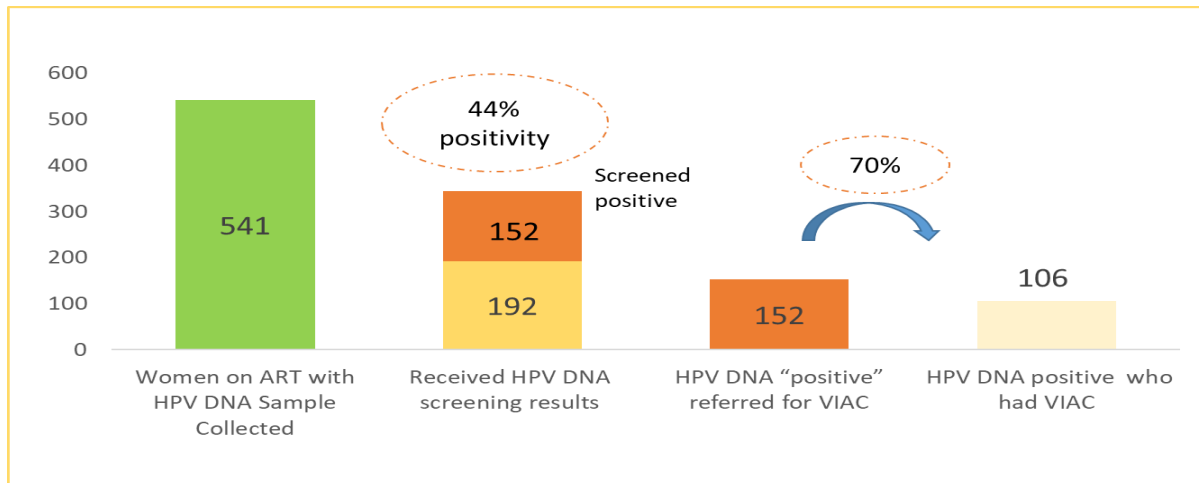


Figure 28: HPV DNA Testing Cascade (Makoni District)

6. To advance and strengthen strategic information and evaluation for data driven and evidence-based implementation.

6.1 Data Management and Reporting

The ACCE project data management and reporting system is aligned to the MOHCC HIV program's monitoring and evaluation (M&E) system. The program monitoring system comprised of weekly, monthly, and quarterly data management. MOHCC data management and reporting tools (MRF), plus an additional tool (Quasi-MRF) were used to collect data that were not routinely collected through the MOHCC system. The Quasi-MRF collected finer age/sex disaggregated data which feeds into additional indicators required by PEPFAR. Both the MRF and the quasi-MRF were completed and submitted to district offices for analysis every month for all routine indicators. Weekly data were also collected for key performance indicators (KPIs) required for the High Frequency Reporting (HFR).

6.2 Routine Data Quality Assessments (RDQA)

As part of comprehensive data quality assurance strategies, the SIE team conducted routine data quality assessments in selected health facilities in Manicaland and Midlands provinces for FY22. The team used a standard RDQA tool that incorporates assessments of the availability of critical M&E tools, completeness of documentation in tools and verification of submitted data in program DHIS 2 databases vs. totals on monthly report forms and recounts from primary source documents. It also looks at various program issues such as the documentation of registers, the M&E system, data use and utilization at facilities.

6.3 Availability of M&E tools

The ACCE project supported the printing and distribution of data management materials in supported districts between October 2021 and September 2022 (Table 11):

Table 11: Monitoring and Evaluation Tools

Type of Support	Quantity
Printed and distributed Defaulter Tracking Pocket Diaries	1,300 pocket diaries
Distributed ART registers (Global fund printed)	500 copies of ART Registers
Printed and distributed HIV index contact tracing registers	561 copies of HIV index contact tracing Registers
Printed and distributed Viral Load Registers	650 copies Viral Load Registers
Printed and distributed TPT Registers	700 copies TPT Registers
Printed and distributed Defaulter tracking registers	500 copies Defaulter Tracking Registers
Printed and distributed Viral Load Request Forms	200 copies Viral load request forms booklets
Printed and Distributed 2022-2024 Appointment diaries	450 appointment diaries
Distributed DSD Register	500 copies DSD registers
Distributed Prep registers (global fund printed)	340 copies
Printed and distributed MOHCC Monthly return forms	16, 076 copies
HTS Register (with new Algorithm)	748 copies
DNA PCR Clinic register	500 copies
Printed and distributed Opportunistic Infections/Antiretroviral Therapy (OI/ART) Care booklets	25,2441 Copies
VIAC Registers	300 copies

6.4 Electronic Health Record Support

ACCE project offered technical support to the MOHCC's Electronic Health Record (EHR) implementing sites in Manicaland and Midlands provinces. Technical support in the form of system roll-out, user training didactic and onsite training which had a support and mentorship component which is an on-going process. With the help and engagement with ICAP thus, the two provinces were installed with both EHR web version and mobile version after data migration from ePMS. Data capturing and back-log clearing was achieved by employing e-First data capturing model coupled with back-capturing after green-book transition exercise which was more focused on ART clients in ACCE supported districts. Table 12 summarizes EHR coverage for Manicaland and Midlands districts.:

Table 12: Electronic Health Records Coverage

District	Number of Sites	EHR Implementation			EHR Coverages
		Mobile	Web	Total	
Mutare	51	16	32	48	94%
Makoni	56	0	28	28	50%
Buhera	33	0	16	16	48%
Chipinge	48	0	19	19	40%
Mutasa	46	35	8	43	93%
Gokwe South	34	2	21	22	65%
Gweru	33	2	30	32	97%
Kwekwe	38	2	32	34	89%
Mberengwa	34	0	34	34	100%
Total	373	57	220	276	74%

Most of EHR sites were using Web version more than mobile, this is attributed to the need for reliable connectivity which syncs offline captured data whenever connectivity is available. Plans for FY23 is to collaborate with the EHR implementing partner to saturate (funds permitting) all facilities in supported districts with EHR for reporting and conduct onsite focused trainings for system users which will improve both system and data utilization.

6.5 High Frequency Reporting

The project adhered to high frequency reporting (HFR) guidelines, timelines, and templates. Weekly HFR was used to monitor program performance for selected key performance indicators. The ACCE project successfully submitted HFR data every four weeks with results broken out in weekly increments to USAID. Relevant HFR data visualizations such as clinical cascades, charts, graphs, and dashboards were pinned in DHIS II and Power BI. Weekly program performance review meetings were conducted at national and district levels, with action plans for continuous program improvement developed.

6.6 Data Quality Assessments

All the RDQA in FY22 Q1, Q3 and Q4 were conducted by the district teams supported by their PSIEOs. The National team carried out the DQA in Midlands and Manicaland in Q2 for Q1 FY22 data and only 7 districts were visited. The RDQA were carried out with support from the MOHCC DHIOs in all the 9 ACCE districts. The districts that had their data verified by the national team are shown in the table below

6.7 Knowledge Management

Several activities were implemented across DREAMS-RISE and ACCE projects, with Knowledge Management (KM CLA, Strategic Information and Evaluation (SIE) and Communications staff effectively collaborating in activity design and implementation. Some knowledge management highlights for the period under review include development of a five-year KM strategy, development of data protection policy, institutionalization of quarterly KM bulletins, media training for technical and operations staff and deep dives focusing on program gaps. Other activities include development of conference abstracts, participation in conferences (ZiMA and Interest), development of manuscripts, successful launch of ACCE and RISE projects, development of success and human-interest stories, as well as design and implementation of digital data management and visualization platforms.

6.7.1 Informatics Innovations

In-order to strengthen informed decision making for patient care and management, the informatics team revamped and improved use of digital systems through new and reliable innovation. Digitization being the thrust for the informatics department improved data collection, reporting, and dissemination of patient level and aggregated data. The selected tools were rigorously tested, and lessons learnt in their usage was used for further optimization. The informatics team conducted user trainings at national and sub-national levels coupled with development and dissemination of user guidelines and respective SOPs. During the period under review, the team strengthened use of digital platforms which includes but not limited to:

Longitudinal and surveys data

- Kobo Collect – ZHI is using Kobo Collect for digital survey form designs both for mobile and web application which feeds into visualization tools like Power BI and Tableau. Most of the Tracker Apps under implementation are making use of Kobo, thus, to include both community and facility trackers and data being used for deep dives.
- Defaulter Tracking App – This is a mobile App for OI/ART client’s follow-up, which is in pilot phase at Vengere clinic. The app will be rolled out in a phased approach with an initial focus on Tier I sites. The app is complimenting the already existing patient level systems on defaulter tracking down to the community.
- EHR and EPMS – ZHI supported MOHCC in rolling out the two patient level systems, user trainings and mentorship visits to improve data use, completeness and accuracy for patient management and programming.
- REDCap - REDCap now on go-live stage though primarily accessible from the national office awaiting hosting it for all implementing levels’ access. REDCap will be used for survey data collection and analysis. ZHI was registered as a member of the REDCap consortium, and a free license was approved and awarded to ZHI.

Aggregated data and visualizations

- DHIS2 – DHIS2 is being used as the aggregate data repository for data being captured at sub-national level. The informatics department initiated a process of exporting data direct into Data for Accountability, Transparency, and Impact (DATIM) in-order to do away with double entry and the need for an error free process when pushing data into DATIM.
- Power BI – A very useful visualization tool which can manipulate and transform data captured by both patient level and aggregated data systems. Integrating Power BI and other digital data collection tools i.e., Kobo, ZHI team can now review facility and community daily performance in the Situation Room Meetings using dashboards.
- Tableau – For low resource settings, Tableau has been and is being implemented as visualization tool like Power BI.

With continued system user follow-up, feed-back and research, the informatics team envisage and will continue being innovative for the continued digital programming for informed decision making. Informatics team is making sure ZHI achieves user-satisfaction with robust digital innovations to improve program monitoring as we move towards a paper-less working environment.

6.7.2 Evidence to Action

Table 13: Evidence to action for abstracts developed

Deep dive	Key Findings	Programme Implications
Cervical cancer screening positivity rate, clinical management, and outcomes for women screening VIAC positive in Manicaland and Midlands provinces, 2022.	<ul style="list-style-type: none"> • VIAC positivity among HIV positive women screening for the first time was 5.9%, in line with targets. • Treatment coverage was high (90%). • Turnaround time from diagnosis to treatment met national standards. • Post-treatment coverage for eligible women in the follow up period was suboptimal. 	Design and implement innovations to optimize 6-month post- treatment coverage.
Effectiveness of differentiated service delivery (DSD) models in treatment continuation of ART clients during the Covid-19 Era in Manicaland and Midlands provinces, 2021.	<ul style="list-style-type: none"> • DSD model coverage suboptimal • The Fast-Track model was the most common but with inferior treatment continuation compared to other models • Treatment continuation better for clients in CARGS, Adolescent Clinic, Family Refill and Facility Club models 	Increased focus on DSD model enrolment, prioritizing models with superior treatment continuation.
Improving viral load coverage using a continuous quality improvement approach in selected health facilities of Gweru district.	<ul style="list-style-type: none"> • Across the 3 sites implementing CQI projects, viral load coverage improved from 69% in September 2021 to 76% in June 2022. • Viral load coverage at Mkoba Poly clinic improved from 63% in September 2021 to 71% by June 2022. • Similarly, viral load coverage at Ntabamuhlope clinic improved from 34% to 69%, and at Mkoba I clinic from 68% to 88% in September 2021 and June 2022 respectively. 	Implementation of CQI projects significantly improved viral load coverage at the 3 implementing sites. We recommend scale up of this approach to other sites in the district.
Using a quality management and improvement approach to optimize quality of cervical cancer screening images and their proper interpretation in public sector health facilities: lessons from Zimbabwe Health Interventions.	<ul style="list-style-type: none"> • There was overall improvement in proportion of images meeting quality standards (absence of excessive light reflection, discharge, and shadows, and well-focused image capturing the whole transformation zone) from 40% in February to 72% in June 2022. • There was an overall improvement in concordance between diagnosis given by clinicians after VIAC and those given by experts during quality review meetings from 50% in February to 88% in June 2022. 	Implementation of VIAC quality management and improvement initiatives improved quality and interpretation of images by clinicians. We recommend institutionalization of quality management and improvement initiatives within the national VIAC program.
Improving data visualization and use for HIV programming through use of digital analytic tools (Power BI).	<ul style="list-style-type: none"> • Power BI is secure, can connect many data sources and “brings data to life” through interactive dashboards. • With Power BI, one can pull in data from a wide range of systems (databases) in the cloud 	Power BI greatly improved routine data analysis, visualization and use for ZHI’s HIV care and treatment and

	<p>and on premises and create dashboards that track key performance indicators (KPI).</p> <ul style="list-style-type: none"> • This has enabled granular analysis and visualization of data which is critical for enhancement of data use at national and subnational levels. 	DREAMS-RISE programs; this has facilitated real-time decision making critical for program optimization.
Digital technology in HIV care and treatment: Utilization of a light defaulter tracking application to enhance continuity of treatment among clients on antiretroviral therapy.	<ul style="list-style-type: none"> • Qualitative feedback from HCW indicated that the application facilitates easy identification of clients missing appointments. • The bulk SMS functionality was effective in ensuring every client who missed an appointment was reminded and this lessened the burden associated with manually texting every client. 	The defaulter tracking application has potential of strengthening the current appointment system which is largely paper based and relies on well documented appointment register. The application brings an innovation that is efficient and allows health care workers to focus on other core duties.
Optimizing TB preventive therapy uptake among people living with HIV at Gweru provincial hospital using a quality improvement approach.	<ul style="list-style-type: none"> • Review of clients' folders facilitated identification of clients eligible for TPT. • Engagement of community health workers facilitated follow up of TPT eligible clients resulting in higher initiation rates. • Addressing the demand and supply side program gaps resulted in improvement in service uptake. • HCW capacity building and engagement of community lay cadres improved documentation, and use of appointment system increased TPT uptake for Gweru provincial hospital. 	We recommend implementation of these interventions in other facilities in the district.
Improving clinical management of clients with high viral load through implementation of Enhanced Adherence Counselling (EAC) Clinics in Kwekwe District, Midlands Province, 2022.	<ul style="list-style-type: none"> • EAC clinics provided a platform for clients, facility staff and ZHI program officers to achieve the best possible outcomes for HVL clients. • These clinics facilitated discussion of clients' challenges in accessing HIV services. • The platform enabled peer counselling and support; long-term relationships were natured enabling peer support beyond EAC clinics. 	We recommend scale-up of this promising intervention to all facilities and consenting clients.
Applying the Total Quality Leadership and Accountability (TQLA) in HIV programming: lessons from FHI360/ZHI TQLA implementation.	<ul style="list-style-type: none"> • Situation room meetings (SRM) created a platform for program ownership and accountability. • Participants ensure that the feedback they give is correct and consistent with what is happening in their respective districts. • SRM provides a platform for lower-level cadres to participate in decision making. 	The MOHCC AIDS and TB Programs will be engaged for them to join the SRM, and ZHI advocated for inclusion of SRM concept in the HIV

	<ul style="list-style-type: none"> Weekly performance review meetings have become shorter due to most of the issues being discussed during SRM. 	Quality Management Guide
Outcomes of children living with HIV transitioned to Dolutegravir based antiretroviral therapy regimens in Midlands and Manicaland Provinces of Zimbabwe, 2022.	<ul style="list-style-type: none"> 635 (72.3%) children were switched to a DTG based containing regimen Of the 220 children who had a viral load <1000 before DTG transition, 216(98.1%) of them had a viral load remaining <1000 and four had a viral load >1000. Of the 56 children who had a viral load >1000, 48(86%) had suppressed after transition to DTG based regimen and 8 remained unsuppressed Children who remained on a non-DTG containing regimen were 8 times more likely to have unsuppressed VL compared to those who switched to DTG (RR 7.86, 95% CI 2.4-25.2). 	We recommend scaling up of DTG regimen switch for all children to improve their virological outcomes.

6.7.3 Conference Abstracts

Several abstracts were developed and submitted for consideration for presentation at local, regional, and international conferences including Zimbabwe Medical Association (ZiMA), Interest and International AIDS Society (IAS). Table 134 summarizes abstracts developed; conferences submitted to and outcomes.

Table 14: Conference Abstracts

Abstract	Conference	Outcome	Comment
Assessment of viral load monitoring among people living with HIV across selected health facilities in Manicaland and Midlands Provinces before and during COVID-19 Era.	Interest.	Accepted for poster presentation.	Presented virtually.
Assessment of management of clients with high HIV viral load in Manicaland and Midlands Provinces in the era of COVID-19 pandemic, 2021.	Interest.	Accepted for poster presentation.	Presented virtually.
Assessment of healthcare worker adherence to viral load monitoring algorithm for HIV positive pregnant and breastfeeding women on ART in Manicaland and Midlands provinces during COVID-19 pandemic, 2021.	Interest.	Accepted for poster presentation.	Presented virtually.
Using routinely collected data to assess HIV early infant diagnosis turnaround time in Manicaland and Midlands Provinces, 2021.	Interest.	Accepted for poster presentation.	Presented virtually.
Assessment of cervical cancer screening positivity rate, clinical management, and outcomes for women screening VIAC positive in Manicaland and Midlands provinces, 2022	ZiMA.	Accepted for oral Presentation.	Presented as Oral abstract.
Assessment of effectiveness of differentiated service delivery (DSD) models in treatment continuation of ART clients during Covid-19 era in Manicaland and Midlands provinces, 2021	ZiMA.	Accepted for oral presentation.	Presented as Oral abstract.
Improving clinical management of clients with high viral load through implementation of enhanced	ZiMA.	Accepted for oral presentation.	Presented as Oral abstract.

adherence counselling (EAC) clinics in Kwekwe district, Midlands province, 2022.			
Outcomes Of Children Living with HIV Transitioned to Dolutegravir Based Antiretroviral Therapy Regimens In Midlands and Manicaland Provinces Of Zimbabwe, 2022.	USAID 4th Annual Local Partner Meeting.	Accepted for panel discussion.	To be presented as panel discussion.

6.7.4 ACCE and DREAMS-RISE Launch

The launch of ACCE and DREAMS-RISE project activities was conducted on the 1st and 2nd of September 2022. The launch showcased ZHI's innovations and accomplishments in support of the achievement and sustenance of HIV epidemic control in Zimbabwe. This launch was coming against a background that a) ZHI is a relatively new organization and current projects had not been officially launched, and b) there were limited platforms to interact with sub-partners, collaborating institutions, GoZ line ministries, and UN agencies, and c) there was need to share our implementation approaches, program innovations, achievements, and knowledge management products with wider stakeholders. We had about 140 participants drawn from government of Zimbabwe (GoZ) key line ministries, UN agencies, academic institutions, PEPFAR, USAID, NAC, potential funding agencies, representatives of people living with HIV, program beneficiaries, print and electronic media, and other PEPFAR and non-PEPFAR implementing partners.



Figure 29: Picture 1: USAID Acting Deputy Mission Director, Priscilla Sampil, giving remarks at the ACCE & RISE Programs Launch, Harare, Zimbabwe, September 2022

The USAID Acting Mission Director expressed how USAID was impressed by the exceptional results that were achieved by the two ZHI projects since implementation started in October 2021 “This is why I am honoured to be here today to launch two new projects ZHI projects. “The ACCE project is developing innovative and sustainable high-impact health solutions and strengthening communities. While it was launched nine months ago, the ZHI team has already reported impressive results. They have reached more than 180,000 people with HIV testing services, initiated over 9,000 individuals who tested HIV positive with lifesaving ARVs, and supported provision of and access to regular antiretroviral therapy and HIV services to over 213,000 people.” Priscilla Sampil said. “In just nine months, the RISE project, under the DREAMS initiative, has reached more than 103,000 adolescent

girls and young women with HIV and sexual violence prevention services, and almost 16,000 with economic strengthening interventions.” She added.

6.7.5 Quality Improvement

The ACCE project supported design, implementation and institutionalization of continuous quality improvement initiatives using two models i.e., PDSA and Total Quality Leadership and Accountability (TQLA). TA and capacity building of ZHI and MOHCC staff was conducted through didactic trainings and mentorship and coaching of site-level staff. Capacity building focused on identification of service delivery areas with performance gaps, problem and root cause analysis, development of CQI plans, implementation, and review of planned activities, and CQI documentation. Facilities were encouraged to implement a minimum of 2 and maximum of 3 CQI projects per given time. Most of the CQI projects targeted viral load monitoring, index case testing, TPT initiation, and ART linkages.

Some of the CQI activities implemented include:

- Total Quality Leadership and Accountability Training (TQLA) of ACCE and MOHCC staff.
- TQLA Mentorship in Manicaland and Midlands.
- Clinic Lab Interface meetings
 - CLI meetings were routinely conducted at facility level to address challenges in the Viral Load cascade. ZHI coaches conduct facility based CLI meetings with support from District MOHCC HIV Focal Persons. The meetings make use of the PDSA model to come up with course correction measures as well as plans to address the gaps in the Viral load cascade. There were no trained MOHCC CLI coaches in Manicaland and Midlands Provinces.
- Routine Site Support visits and facility-based mentorship
 - District leads from both ZHI and MOHCC carried out routine site support visits to facilities, providing on-the-job training and mentorship. ZHI teams planned collaboratively with MOHCC teams, identified facilities with suboptimal performances or facing challenges that needed support. During the visits, the team reviewed facility performances and came up with plans to address the challenges. All facilities in a District were visited at least once every quarter to keep abreast with what was happening and provide routine support to the facilities. Respective facilities were supported by ZHI and MOHCC mentors in developing Quality Improvement Plans to address poorly performing indicators.
- Cervical Cancer Quality Control meeting

6.7.6 Total Quality Leadership and Accountability (TQLA) Training

With support from FHI 360, 41 ACCE and MOHCC staff were trained on Total Quality Leadership and Accountability (TQLA) from 23-27 May 2022.

TQLA is an innovative and adaptive management approach which focuses on the following:

- strengthening capacity of implementers at all levels to be more accountable
- using data to strategically prioritize local solutions to solve development challenges and improving outcomes at lower costs.

One of the key outputs from the TQLA training was the implementation of the situation room meetings (SRM). The SRMs were conducted daily with SIE and program staff at national, provincial, district and health facility levels. This involved performance review of HTS and ART linkages data. Action plans were developed for service and data quality improvement and were followed through for

implementation. The daily SRM was conducted virtually on Teams between 8-9am, Monday to Wednesday affording an opportunity to understand programming at a lower level and offering real-time feedback to staff on action to be taken.

7. Look and Learn Visit to Zambia

In preparation for COP22 annual work planning, ZHI conducted a look and learn visit to FHI 360's mature HIV prevention, care, and treatment project in Zambia's Eastern Province from June 12-18, 2022. Objectives of the look and learn visit were:

- Appreciate TQLA implementation,
- Learn and adapt best practices,
- Exchange ideas, and
- Learn innovations from a mature HIV prevention, care, and treatment project.

Several best practices were noted and considered for adaptation in the ACCE implementation context. These interventions include HIV case finding among pediatric clients through index case testing, the GBV program which is fully integrated into the HIV program, IEC materials and job aides for clients and HCWs respectively, telemedicine for management of clients with high VL and continuity of treatment interventions.

8. To Provide Technical Assistance at All MOHCC Levels

In the first year of implementation, the ACCE project provided technical assistance (TA) through participation in several technical working groups (TWG) including advanced HIV disease (AHD), PrEP, DREAMS and M&E TWGs. ACCE also provided TA to MOHCC through participation in the adaptation process of the July 2021 WHO HIV Prevention, Care and Treatment guidelines. There is anticipation of launch of the guidelines during the first quarter of COP22, and the project is already making plans for the dissemination as well as capacity building of HCWs in the supported districts in COP22. ACCE provided TA to MOHCC through active participation in the development and updating of cervical cancer screening and treatment guidelines which are now at an advanced stage and training curriculum for expert patients.

The SIE team provided TA to MOHCC on SIE issues including scaling up of EHR, and patient care booklet transition. The technical team also participated in the development of job aides for both 3HP and pediatric DTG towards the scaling up of these key interventions. ACCE also provided capacity building of MOHCC staff to enable implementation of the interventions. To provide high quality and comprehensive technical assistance to MOHCC, the ACCE project supported the two provinces to hold the semi-annual review meetings at provincial levels. These provided platforms for technical assistance particularly for the TA districts.

9. Implementation Challenges and Course Corrective Actions Taken

Table 15: Implementations Challenges and Course Corrective Actions

	Challenges	Course corrective actions
1	Persistent shortage of commodities (TB medicines and HIV testing kits (INSTI) etc.).	<ul style="list-style-type: none"> Supporting sub-national coordination forums for supply chain management issues. Capacity building of project and site-level staff on supply chain management.
2	LIMS challenges at provincial laboratories resulting in VL samples being referred to other provinces for processing increasing turn around turnaround time and missing results.	<ul style="list-style-type: none"> Continuous tracking of samples and Engagement of laboratory partner to resolve LIMS challenges through CLI.
3	High staff attrition affecting mainly middle and low volume sites implementation and continuity of training cascades.	<ul style="list-style-type: none"> Support mentorships and OJT through the MOHCC structures through engaging district and provincial nursing and medical departments. Strengthened district cluster system by motorizing recruited cluster nurses (CNT) and community PCC to support sites with VL collections, TPT, documentation etc.
4	Information sharing challenges between BRTI riders and ACCE teams.	<ul style="list-style-type: none"> Jointly developed SOP to standardize CLI meetings from national up to facility level.
5	Continued sub-optimal performance of areas such as TPT initiation/completion, community indicators, VL coverage and suppression.	Introduction of daily Situation Room Meetings (SRM) with participation of district staff and buy-in from MOHCC. Analysis of site-level and day-to-day targets with immediate course correction. Assigning project specific targets to individual staff and this to be part of the performance goal setting agreement.
6	Retention in care.	<ul style="list-style-type: none"> Improve documentation and adherence to existing mechanisms to improve retention (appointment diaries utilization, completion of the defaulter tracking register) Regular monitoring of retention indicators with immediate course correction through retention meetings at community level as well as at district and provincial level.

10. Environmental Monitoring and Mitigation

During the period under review, the project continued to ensure that all ACCE project staff were aware of the Environmental Management and Mitigation Plan (EMMP); the potential adverse effects that could occur from the implementation of the ACCE activities, and mitigation measures that the project put in place. In FY22, all program staff members were re-oriented on the EMMP. Additionally, the project ensured that waste management project documents i.e., ACEE waste management SOP, waste segregation flow chart, waste management registers and disposal consumables were made available for use by project staff.

Sharps containers and colored waste segregation bags were provided for community activities. Through scheduled regular site support by district, provincial and national project staff, adherence to Environmental Management and Mitigation standards was monitored. USAID assessed this program component during the SIMS visits that were conducted during the period under review. This component was in green for most facilities that were assessed during the SIMS visit.

11. Child Safeguarding

The organization continued to strengthen its safeguarding systems. During this period, the program focused on strengthening capacity of staff, direct program beneficiaries and stakeholders to the programs. New banners and posters on safeguarding were developed as part of information education and communication (IEC) materials to facilitate conversations around protection issues with the community and to share the various reporting platforms available. In addition, a new internal mobile telephone line was introduced to complement the existing list of Community Based Response Mechanisms (CBRM) to facilitate timely reporting and response to safeguarding complaints through voice call, WhatsApp messaging, and the normal short messaging system (SMS).

12. Cross – Cutting Approaches

12.1 ARPA project performance

ARPA project staff were fully on board for all the districts by May 2022. The Covid 19 support was provided based on the 4 main objectives which are:

1. To increase awareness and demand for Covid 19 vaccines.
2. To increase access to covid 19 vaccines.
3. To strengthen District Capacity for effective monitoring of Covid 19 program including increase in quality and availability of routine Covid 19 vaccine program data for evidence-informed decision making.
4. To strengthen supply chain management of Covid 19 vaccines.

Demand creation activities were conducted in all the 8 supported districts in Midlands Province to increase awareness and demand for Covid-19 vaccines. The ACCE project working closely with the already existing structures, health care workers and volunteers, following the low-cost high impact interventions with the aim of reaching target population where they live or spend most of their time conducted community outreach, targeting workplaces, schools and tertiary institutions and Churches.

There was integration of Covid 19 vaccination with the Mass Drug administration for Trachoma and the measles mass vaccination. The joint activities contributed to the increase in demand as the mothers were encouraged to carry their vaccination cards for the measles vaccination or get the vaccination at the same points. The vaccination teams also put the Covid 19 IEC material next to their banners for the Mass vaccination campaign for Measles. Vaccination messages were sent through educational activities and outreaches. There was a partnership with the local radio station YA FM to increase

awareness and create demand on a larger scale. There was advocacy for an increase in uptake through meetings with the employers and the religious leaders. Roadshows and Loud hailing sessions were carried out throughout the districts and proved to be of high impact as more people were reached and notable increase in the vaccine uptake during the period under review.

The administration of the vaccines was conducted using several approaches including facility-based vaccinations for walk in clients, community-based administration at predetermined outreach points and the door-to-door vaccination. These resulted in significant increases in clients receiving COVID19 vaccinations, with 80,973 receiving dose 1, 135,409 for Dose 2 and 70,156 for Dose 3 across the entire province. Table 15 shows the cumulative vaccinations by dose in the eight provinces in Midlands province and as of 30 September 55%, 35% and 8% of doses 1, 2 and 3 respectively had been achieved. With the additional funding in COP22, the ACCE project will continue to support the province to achieve better coverages.

The Program provided resources to increase human resource capacity by supporting nurses to administer Covid 19 vaccines at selected public sector sites, busy community centers and outreach points. The program provided support with lunch allowances and transport to selected sites. The project also supported the low cost My Village My Home door to door campaign to increase vaccination at community level.

ZHI/ACCE supported supply chain management for Covid 19 vaccination commodities, ordering and stock management of covid 19 consumables and vaccines for maintenance of the cold chain. The support ensured last mile delivery of adequate quantities of viable vaccines to vaccination points and sites.

In order to ensure that the data collected by district teams is of high quality, the project conducted monthly COVID19 data review meetings which were led by the District SIE teams, and all facilities were invited. These meetings were also used to trouble shoot and address challenges in COVID19 vaccination at facility level while sharing plans for the coming month to ensure achievement of targets. All districts managed to conduct monthly review meetings and the Provincial Data review meeting was also held in September 2022.

Table 16: Covid-19 cumulative vaccination coverage by dose in the Midlands districts as at September 30, 2022

MIDLANDS PROVINCE COVID 19 VACCINATIONS							
		Dose 1		Dose 2		Dose 3	
District	Target	Cumulative	Coverages	Cumulative	Coverages	Cumulative	Coverages
Chirumhanzu	71,212	46,188	65%	34,232	48%	7,083	10%
Gokwe North	193,360	110,669	57%	57,960	30%	16,490	9%
Gokwe South	269,315	127,269	47%	62,472	23%	11,111	4%
Gweru	230,443	136,508	59%	98,522	43%	23,501	10%
Kwekwe	266,147	116,486	44%	70,345	26%	9,215	3%
Mberengwa	136,128	84,461	62%	50,265	37%	10,304	8%
Shurugwi	88,313	48,603	55%	35,056	40%	5,910	7%
Zvishavane	105,587	83,037	79%	63,481	60%	25,202	24%
Province	1,360,505	753,221	55%	472,333	35%	108,816	8%

12.1 Strengthened Referral Networks and Linkages

The ACCE team strengthened collaboration with stakeholders and implementing partners working in the 2 provinces. As such, mapping exercises were conducted and collaborative meetings were conducted with ZNNP+, FACT, Catholic Relief Services, National AIDS Council, Msasa and MASO to conduct joint planning exercises and explore areas of mutual interest.

12.2 Commodity Management

The ACCE project is now a member of the Supply Chain technical working group (TWG) and it supported the forecasting, quantification, ordering and distribution of HIV related commodities and medicines from facility, district, provincial and national level. Some of the project key performance indicators were affected by stock ruptures, including shortages of INH, pyridoxine, and HIV test kits. Continued engagement of the pharmacy department remains a key priority at all levels.

12.3 Private Sector Engagement

Mutare District had a sensitization session with Mutare Poly Students and initiated 6 students on PrEP during the third quarter of implementation. The farms and mines are being reached through our Districts as they provide support to the Private clinics in Chipinge and Buhera.

13. Linkages And Coordination with Key Government of Zimbabwe Line Ministries and Departments

- The project leadership presented an overview of the ACCE project and progress update for the period October 2021 to May 2022 to AIDS and TB program managers
- In Midlands, a Provincial Review and planning was held with the full support and participation of the PHE and DHE members
- Provincial and district level managers continued to actively engage with the District Development Coordinators and share project plans and progress reports on a quarterly basis
- The AIDS and TB program managers and officers participated in the ACCE semi-annual review meetings and TQLA training workshop
- ACCE project was coopted into the supply chain supply chain technical working group at national level
- ACCE project collaborated with the National AIDS Council (NAC) and MOHCC in coming up with new HIV estimates. In Manicaland ACCE is collaborating with NAC to respond to areas with hotspots of new infections with prevention activities

14. Prime Award Management

14.1 ACCE Prime award management

Through the support of the Compliance, Contracts and Grants (CCG) unit, the ACCE Program ensured that program implementation in COP21 was conducted within the confines of the Cooperative Agreement, USAID Rules and Regulations, national laws/regulations, ZHI internal policies as well as other applicable standards and guidelines. During the period under review, the following key activities were undertaken among others to ensure effective award management:

- A Know-Your-Award (KYA) session was conducted whereby program staff were oriented on the ACCE Cooperative Agreement

- Tools were developed to assist the program management team to track key reporting requirements and deadlines.
- An internal audit exercise was conducted for the program to identify any internal control gaps and areas of operational inefficiency. Recommendations made were fully addressed.
- Compliance reviews were carried out in all the district offices. Reports of findings were shared with the project management team and recommendations were implemented.
- Trainings were conducted for field teams in general administration and fraud awareness. As a result of the fraud awareness trainings, there has been increased usage of the Tip-Offs Anonymous (TOA) platform by project staff to report any misconduct and malpractices. All issues reported have been investigated and reports shared with the senior management for the project. Some of the issues raised were reported to the USAID’s Office of the Inspectorate General (OIG). There are no pending investigations for the ACCE Program.
- Ensured a smooth migration from the DUNS number to the Unique Entity Identifier (UEI) for the organization.

14.2 Special Award Conditions

During the year under review (FY22), ZHI was given six (6) Special Award Conditions (SAC’s) which were to be addressed within a 12-month period. In Quarter Four (Q4), USAID’s Financial Management Office (FMO) conducted a financial review aimed at assessing progress made towards addressing the SAC’s raised. Based on the preliminary feedback received from USAID, three out of the six SAC’s were adequately addressed and recommended for closure. Below are the outstanding SAC’s and status to date (Table 17):

Table 17 : Special Award Conditions

Description	Status
ii. The organization should develop a sustainability plan and pursue other sources of revenue to diversify its funding.	Ongoing - A sustainability plan and a resource mobilization strategy have been developed. ZHI continues to look for opportunities to diversify its funding sources. Several proposals have been submitted in response to various calls that have been advertised. USAID will close this SAC once ZHI proves that it has won another grant in addition to the current USAID-funded awards.

<p>iii. ZHI should consider specifically addressing the issue of board remuneration in its Board Charter. In so doing, the organization should take the following into consideration in making the decision - organization culture, availability of funding, donor expectations, and the image it wishes to portray. It is a general expectation that board members are individuals with a vested interest in the cause of the organization and are willing to give their time toward the advancement of the organization's mission. Consistent with the Board's fiduciary obligation and generally acceptable good practice the organization should consider not remunerating the board and/or should clearly state that donor funding will not be used to pay board members.</p>	<p>Ongoing - The issue has been presented to the Board and was deliberated during the Quarter 4 Board Meeting which was held on the 28th of September 2022. The Board resolved that the language in the Board Charter be revised to align with USAID's expectations. A Board Support and Compensation Policy was approved which details how ZHI board members will be compensated for participating in board meetings and supporting the organization's activities. This has been submitted to USAID.</p>
<p>iv. ZHI should consider reviewing and revising its existing compensation plan to include clear pay/salary scales. This should reflect the minimum and maximum salaries the organization pays for a particular position. The lower side of the pay scale shows how much the organization would pay someone who meets the minimum requirements of a particular position, while the high end indicates how the organization might pay someone who meets all the requirements and preferences of a particular position. An organizational pay scale will also provide the organization with a system to pay employees consistently for the work they do in each position and increase ZHI's ability to effectively budget for labor costs.</p>	<p>Ongoing - A revised compensation plan is being developed following USAID's further guidance after the financial review.</p>

15. Sub-Award Management

During the period under review, ZHI implemented the ACCE program in partnership with two subrecipients namely Africaid (now Zvandiri) and FHI 360. Subaward agreements were drawn and signed with these organizations to guide the partnerships and spell out roles and responsibilities for each party. Continuous subrecipient monitoring was provided with the support of the CCG department through site visits, trainings and monthly subaward financial and programmatic performance reviews. A subaward management toolkit was launched to assist the program team in ensuring effective subaward management. The toolkit provides a one-stop-shop of trackers that assist the program in monitoring key subaward actions, track subaward performance (financial and programmatic) and identify capacity gaps for further strengthening. The following monitoring activities were conducted for the two subrecipients:

- Review and monitoring of Special Award Conditions to ensure fulfillment
- Review and monitoring compliance to subaward terms and conditions and USAID regulations
- Conducting Data Quality Assessments (DQAs) during site visits.

- Financial monitoring to ensure compliance with USAID’s cost principles and organizational policies for allowability of costs
- Overall review for compliance to grant terms and conditions including:
 - VAT reporting
 - Adherence to general reporting timelines
 - Best management practices
 - Compliance with organizational policies and procedures
 - Sound procurement practices
 - Adherence to the approved Branding and Marking Plan and Environmental Monitoring and Mitigation Plan (EMMP)

The contributions of the sub-awardees to program performance during the period under review were as follows.

15.1 Africaid (Now Zvandiri)

Africaid (now Zvandiri) started full implementation at the beginning of Q3. By the end of Q3, they had managed to recruit and train the CATS for the 36 sites being supported 158 CATS were trained and 9 Young Mentor Mother (YMM) YMMs were also trained. The YMMs only cover 9 facilities in Mutare high volume sites and support the PMTCT program. The CATS and the YMM were placed into the facilities by end of May marking the start of actual implementation at site level. By the end of Q3, A total of 5,383 clients which represents 53% of the target had been enrolled for care and support under the Zvandiri model. Among the ACCE key performance indicators, viral load coverage among the CAYPLHIV registered in Zvandiri was 65% (3,123/4,785) and viral load suppression was 87% (2,724/3,123). TPT coverage was also low where only 21% of the referred eligible clients were initiated on TPT. AFRICAID will continue to work closely with the ACCE district teams to improve the performance by;

- Supporting integrated adolescent clinics as well adolescent specific high viral load management clinics to address the low VL coverage.
- Strengthening the support groups for the 0 – 24-year age groups to address adherence challenges using the age-appropriate messaging and counseling.
- Strengthening the linkage and referral pathways for clients identified for TPT to be initiated and ensure completion.

15.2 FHI 360

FHI 360 began full implementation in Q3, and the following were achieved through their support as a capacity development partner.

- 41 ACCE project staff members and provincial and national office participants from MOHCC.
- The ACCE technical team participated in a look and learn visit to Zambia, and this was facilitated by FHI360.

Full details of the support from FHI360 are well detailed under the section on Quality Improvements Updates

16. Finance, Administration and Operations Updates

16.1 Finance Update

USAID obligated a total of USD 11,897,487 to the ZHI ACCE project in October 2021 for the year one implementation. An additional USD 700,000 was obligated for COVID ARPA activities on March 27, 2022, bringing the total obligation to USD 12,597,487. By 30 September 2022, ZHI ACCE Project had received a total of USD 12,597,487, representing 100 percent outlay.

Table 18: Financial Summary

ZHI

Grant Number: 72061321CA00006

Financial summary for Q4

Partner	Total obligated amount	Funds received to date (Oct 2021 – September 2022)	Previously reported expenditure (Oct 21 - June 2022)	Expenditure this quarter (July 22 - September 2022)	Cumulative Expenditure to date (Oct 2021 - September 2022)	Funds remaining against Obligation
ZHI	11,242,714	11,242,714	7,485,400	3,570,753	11,056,153	186,561
SUBAWARDS	1,354,773	1,354,773	574,708	779,954	1,354,662	111
TOTAL	12,597,487	12,597,487	8,060,108	4,350,707	12,410,815	186,672
	100%	100%	64%	35%	99%	1%

Notes to the Financial Report

The current quarter's expenditure is 35% of the obligated amount, and the total expenditure to date is 99% of the obligated amount, leaving a balance of 1%. ZHI had adequate cash flows for all program activities during the quarter. Funds received to date represent 100 percent of the obligated amount.

16.2 Administration and Operations Update Including Procurements

During Q4, 6 (six) Toyota Hilux Double Cab vehicles were received in Harare on July 21, 2022, and 1 (one) Toyota Corolla was received on September 12, 2022. We also received 4 (four) Toyota Hilux Double Cab vehicles on October 03, 2022. The pending 7 Landcruisers arrived in Durban on the 10th of October 2022. The motorbikes as of October 18, 2022, were at Forbes Border Post undergoing physical examination and expected to be released by ZIMRA on October 19, 2022. The 7 (seven) Toyota Landcruisers and 26 motorcycles in transit are all expected in Harare during the second half of October 2022. The delays in the delivery of motor vehicles and motorcycles have been caused by disruptions in the global supply chain.

17. HR Update

Placements of key positions

Placement of key staff was completed including the Strategic Information Evaluation and Learning Director who joined 01 September 2022.

Staff Movement

a. Turnover rate

- In FY22, ACCE received 23 resignations including the Strategic Information Evaluation and Learning Director, Manicaland Provincial Program Manager, Midlands Provincial Program Manager, Strategic Information Evaluation Specialist and Senior Technical Officer. Overall, the staff turnover rate was low during the period under review with 0.12%.

b. Promotions

- The Senior Technical Officer was promoted to Manicaland Provincial Program Manager after the Manicaland Provincial Program Manager resigned.

c. Separation by death

- HIV Care and Treatment Coordinator for Gokwe South passed away.

Reclassification of position

The following positions were reclassified/ remodified in line with project expectations effective 01 April 2022:

Old Position	New Position
PMTCT Nurse	OI ART Direct Service Delivery (DSD)Nurse
T95 Officer	District Implementation Fidelity (IF)Officer

Harmonization of Human Resources for Health (HRH) Salaries

Further to PEPFAR and Ministry of Health and Child Care Human Resources for Health (HRH) salary harmonization, ZHI is in the process of harmonizing salaries for HRH nurses.

18. Plans/Priorities for FY23 Quarter I

The first year of the ACCE FYI implementation provided the project with an opportunity to assess its performance and more importantly assess program gaps as well as opportunities to introduce innovations to improve program performance. Below are some of the priority areas for the coming year based on the gaps identified in the period under review:

Prevention

- Capacity building of HCWs in DREAMS / GBV / IPV training.
- Strengthened collaboration with the DREAMS community partners (FACT and ZHI – RISE) project to improve PrEP uptake among AGYW.
- Strengthening PrEP implementation among high-risk populations including Pregnant and lactating women (PLW).

Case finding

- Strengthening ICT for the general population and children through
 - Incorporation of ICT within the SOPs for management of high viral loads to ensure all high VL clients are offered ICT.
 - Implementing the “Know your Child’s HIV Status” to improve pediatric case finding.
- Support implementation of recency testing across project sites through
 - Capacity building of both project and MOHCC staff.
 - Ensuring commodity security and availability of job aides.
 - Incorporating recency testing performance into the weekly data reviews.

Linkage and Treatment continuity

- Implementation of site level problem-based QI projects to address TPT, VL coverage etc. The Provincial Technical Officers coming on board will be key in the implementation and monitoring of CQI components.
- Scaling up of EAC clinics for the management of clients with high VL through enhanced monitoring.
- Capacity building of CRFs and OWs on retention and treatment literacy.
- To scale up pDTG transitioning to ensure 95% of children on ART are on a DTG – based regimen by end of COP21
- Cervical Cancer Screening quality assessment and establishment of the quality control program.
- Support scaling up of advanced HIV disease (AHD) management across all ACCE supported sites through capacity building of staff on the clinical and diagnostic components of AHD
- Strengthening and expanding DSD models through capacity building and formation of CARGS, Club refills through collaboration with AFRICAID and CSR.

19. Success Story

Program Update: Community engagement breaks barrier to access cervical cancer services in Buhera

The story of Chapwanya clinic, located about 68 kilometers from Murambinda growth point, Buhera Manicaland, tells it all: “Active use of inclusive awareness campaigns is a game changer in eliminating barriers and misconceptions in cervical cancer screening”. The Chapwanya clinic has a total of 448 active HIV patients.

The ZHI Buhera district team has been providing cervical cancer screening services since October 2021. In June 2022, the facility conducted an awareness outreach but only a few women turned up for this activity. The ZHI District Cervical Cancer Officer (DCCO) sensitized the facility staff that the only way to improve health access was to engage the male partner in cervical cancer screenings.

Male partners of the targeted women aged 25 to 49 were invited to come for a comprehensive health education talk. Pamphlets were given to everyone explaining in detail the background of cervical cancer.

On the August 20th, 2022, the meeting was conducted with the participation of key local leaders that included the District HIV focal person, MoHCC VIAC nurse, Primary Care counsellor (PCCs), Environmental health Technician (EHT), Clinic nurses, Village Health Workers, the Male Mobiliser, and the Headman. The DCCO spoke to the community about health explaining in detail the background of cervical cancer, definition of cervical cancer,



Figure 30: District Cervical Cancer Officer (DCCO), Picture 2; Buhera, Sandra Mvududu giving health education to the community on benefits of cervical cancer screening at Chapwanya clinic.

risk factors for cervical cancer, prevention of cervical cancer. Each participant was given a pamphlet, and the cervical cancer officer explained the health talk using a large chart. Each of the 41 male partners was accompanied by his wife. The male partners agreed to accompany their wives to the screening room for them to appreciate the screening process as well.

The DCCO provided an extensive information package on cervical cancer screening, TPT, viral load services, treatment continuation, PrEP, and index case testing, emphasizing the importance of direct service delivery (DSD) models. Following the presentation, 41 HIV positive women were screened for cervical cancer, 20 clients' viral loads were collected, 15 clients were started on TPT, and four community ART Refill groups were formed. During the health discussion, the male partners expressed many misconceptions, with most of them saying the following in the local language:

“Mukatarisa vakadzi vedu zvibereko zvinozokanganisa bonde”, “hazvigoni kurega bonde kwemasvondo matanhatu pamunenge marapa mudzimai wangu chero mukati tishandise macondom, chokwadi mudzimai wangu wemumba ndingamushandise condom here?”

It is not possible to abstain from sex for six weeks while my wife is on treatment, even use of condoms, is not acceptable to have protected sex with my wife.

'Kana Mudzimai wangu akazonzi anoda kurapiwa na Chiremba idambudziko kuzowana mari yekuenda kwa Murambinda. Saka mudzimai wangu ngaarege hake kutariswa na Chiremba pane kuzoshungurudzika tazoshaya mari yekuti arapiwe.'

If my wife is diagnosed for further treatment, it will be difficult to raise transport money to travel to Murambinda Hospital. As a result, my wife should not be screened because we will be unable to afford the bus fare.

'Ko imi ne program yenyu munodii kungofamba nemaChiremba achingorapawo sezvinoitwa nana mukoti.'

"Why don't you (DCCO) and your program (ACCE project) collaborate with doctors who provide free mobile cervical cancer treatment?"



"Takanzwa kuti mudzimai akatariswa haazozvari kana kuti anozoenda kumwedzi kasingaperi nekuda kwechisimbi chamunoshandisa sezvo zvichinzi chisimbi chenyu chinombobvisa chibereko panzvimbo yacho."

"Hearsay has it that if a woman undergoes cervical cancer treatment, she will be unable to conceive and/or will experience irregular menstruation due to the instruments used for treatment as the iron is said to disturb the positioning of the uterus from its place.

Figure 31: Picture 3, DCCO Buhera and Primary Care Counsellor, holding the big chart at a community dialogue at Chapwanya clinic.

"The Health Care Workers (HCWs) on the ground managed to correct all the misconceptions, and knowledge gaps were filled. In summary, community collaboration and male partner involvement play a critical role in sustaining behavior change for cervical cancer screening services, as evidenced by more than 100% improved health access at Chapwanya clinic.

THE END